WHEN TREATMENT IS VIOLENCE: MAKING, TREATING, AND REGULATING ADDICTION IN NEPALI PRIVATE REHABILITATION CENTERS

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We are all creative beings engaged in the art of conscious living, finding death in life, and life in death, but always nurturing life.

Abstract

Situated in Kathmandu, Nepal, this thesis discusses the causes and consequences of placing addiction treatment within the privatizing Nepali healthcare market. Based on fieldwork conducted during the summer of 2018, I examine the ways in which state biopower is exercised in diffuse states, where multiple stakeholders operate to create and maintain a profitable status quo. This status quo involves the dispersal of the exercise of biopower to private actors, in this case for-profit rehabilitation centers, which are privileged to intern and treat addicted individuals on the periphery of state and medical regulatory structures in spaces of exception. I discuss the social processes through which drug abuse discourses, created by private addiction treatment centers, create the substance dependent as immoral individuals, effectively revoking their right to make claims of safety on the state. Finally, I examine how the lines between violence and therapy are blurred within private addiction treatment centers through narratives describing mistreatment and torture within the treatment setting.

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Chapter 1. Introduction

As one takes the elevator from the fourth to the seventh floor of a popular mall in downtown Kathmandu, the glow of the neon signs offering shoes and Japanese inspired styles fades into the grey hues of bare concrete. The elevator slumps into its track, and one emerges to see an unused movie theatre food court, with tables stacked to the sides. While the changing scenery is generally striking, going from the bustle of a busy mall to the quiet of vacant space, one's attention is stolen by the shape of chairs stacked into igloo forms with small entrances into which a person could crawl. Surrounding these strange stacks and scattered into the bathrooms, are the pages of forgotten newspapers, well-smoked cigarette butts, and the occasional syringe. The needles lay just as idle as the neighboring candy wrappers, waiting to be picked up, swept away, or forgotten, despite being objects imbued with so much meaning as harbingers of illness, danger, and death. The silence of the vacant floor is occasionally broken by the contrasting tones of young people's laughter downstairs in the mall, enjoying their day off.

The bodies of young middle-class drug users who come to smoke and inject in these makeshift sanctuaries and bathrooms around the mall are themselves meaning laden objects, socially marked as immoral, unproductive, and harmful to familial prestige. There are external marks of drug use; track marks, scars, and upwellings where needles have been inserted into calloused skin, but markings which define immorality are a part of processes that define the worth of a human life based on behaviors of ingestion. In the context of private rehabilitation treatment in Nepal, individuals who possess a marked body can become entrapped within state and nonstate structures meant to manipulate behavior as a means of normalizing the body. Within Kathmandu-based state-entrusted private drug rehabilitation centers, projects of bodily normalization frequently blur lines between treatment and torture.

> There are many cases like that, and the police would not come. The people in the center would say, the family has given permission to us. Many people have died over there but they say that they had the family's support… every year we hear about two or three cases of people dying

Manoj[1] had been explaining this world to me for the past few months at the government Opioid Substitution Center where he worked as counselor, mentor, and teacher. While he currently works in a public institution, Manoj was treated for addiction in numerous private centers. Throughout his narrative of recovery, he had also met many individuals whose parents placed them in centers against their will. Coming to OST, many have stories about the way these centers operate. Manoj said: "I have visited many rehabilitation centers. I saw that they beat people, with rods, it's a horrible thing...These centers can make people quit but treat? How to treat? Which way to treat?"

This paper will examine the "politics of everyday life" surrounding drug treatment in Kathmandu Nepal (Fassin 2009). It will confront the ways in which governmental and non-governmental sources in Nepal's rapidly privatizing healthcare sector provide by treatment and explain how private rehabilitation centers have become spaces of exception utilized by the government to remedy the problem of drug addiction but not subject to the laws of the state. Within this examination I will provide an analysis of the ways in which drug addiction and addicts are formed, as addiction is a partially medicalized condition, able to be created and re-created in the public imagination. Following the experience of those who are treated at some of these centers, I will show the means through which treatment and violence become overlaid through addiction's framing as a moral and behavioral abnormality. These dehumanizing

[1] The names of collaborators who volunteered their time to create this piece have been changed to pseudonyms. Pseudonyms using family surnames were changed in a way which maintained caste identity to not obscure the potential role of caste in this study. For a discussion of the contemporary politics surrounding caste and ethnicity in Nepal see Subedi 2011 and Gellner 2007.

constructions and the violence they engender are resisted inside and outside these spaces of treatment, creating new ways in which politics are engaged and existence and identity are articulated.

The Global Scope of Opioid Abuse

The increasing number of individuals beginning the practice of injecting opiates is related to the globalization of opiate based pharmaceuticals and their improved availability (UN Office on Drugs and Labor 2018). What has been described as the "North American Opioid Epidemic," caused by liberal pharmaceutical administration and high rates of chronic pain, has dramatically increased overdose rates and spiked emergency room visits (Kolodny et al. 2015). Public health literature has called this uptick in morbidity and drug-related illness an 'epidemic', reflecting the quadrupling rates of opiate overdose during the period between 1993 and 2010 (Hasegawa et al. 2014).

While this is far from the first drug-related 'epidemic' in North America, the opioid problem presents a new way drug abuse is understood and experienced. Although pharmacologically similar substances may be abused, anthropologists note that cultural and political factors determine a person's "addiction trajectory" (Bourgois and Schonberg 2009; Rakheil and Garriott 2013). The increase in opiate abuse is a public health phenomenon creating a new 'addict' and a corresponding narrative surrounding who should be blamed for the addicted person's illness, how their illness should be treated, and that their illness is a disease, not a personal failure (Hansen and Roberts 2012). Opiate addiction has recreated conceptions of disease through imaging technologies and brain-based treatments, and has changed the social construction of 'the addict' as substance dependence has become more associated with white individuals (Campbell 2010; Mendoza et al. 2018). Correspondingly, the new drug addict is

treated using racialized treatment mechanisms in new spaces and social spheres of medicine, also conforming to new conceptions of the racial, social, and economic identity of the 'new addict', leading some to suggest that biomedicine has created two systems of medicine, one for black and Latin heroin addicts, another for white pharmaceutical opioid addicts (Hansen and Roberts 2012). Opioid addiction, as a partially medicalized illness, has created new meanings, understandings, and frameworks surrounding definitions of illness and treatment.

Considering the global scope of both addiction and its related diseases, inquiry into topics concerning addiction in the global south is imperative. While North American sources of media have situated opiate addiction as a North American issue, the global rate of substance abuse related death has increased by 60%, with opioids causing the highest rate of drug related deaths (UNODC 2018). Many users switch to intravenous injection, meaning diseases such as HIV and Hepatitis C (HCV) are becoming increasingly common among these populations, further complicating their treatment. Recent studies have found one in eight people who inject drugs are HIV positive (UNODC 2018).

The primary response of the international community to the global addiction problem have been efforts to control the supply of drugs through criminalizing their sale and use. Rather than reducing supply, these efforts have pushed drug use to the peripheries of society, significantly worsening the health of drug users worldwide (Room and Reuter 2012). While initiatives like the UNODC/WHO Global Initiative on Primary Prevention of Substance Abuse address addiction as a global public health concern, they focus on youth drug use prevention, rather than the treatment of existing users (UNODC/WHO 2018). Given these drastic health implications and the lack of response from the INGO/global aid community, as well as from local governments, one must ask: Who treats drug abuse in the global south?

To answer such a question, one must account for localized understandings of drug use and confront the diverse ways biomedicine has been incorporated into systems of healing. Authors have examined how the central assumptions of biomedicine, such as the ways in which illnesses are named, treated, and understood, break down outside of western cultural contexts. These consequences go further than rhetorical understandings, and have real effects on the ways in which individuals are diagnosed and treated, as well as how global and local health statistics are created (Finkler 2004; Street 2014). Despite the naturalization of biomedical tenants in many contexts, biomedicine is never adopted as a singular method of healing. Margaret Lock states, "In no case, not even in Europe and North America, has biomedicine entirely usurped other forms of healing practices already present. Pluralism is the norm and, paradoxically, with globalization, diverse forms of medical practice have actually proliferated...The existence of pluralism means that patients often have a choice with respect to different types of medical practitioners" (Lock 2003). Plurality often coincides with global trends towards healthcare privatization. These overlapping trends create a situation in which multiple regimes of care are possible for a variety of conditions (Keaney 2002). Among illnesses being treated in the pluralized field of care, addiction is unique in the ways in which it is overlain by juridical structures and loosely affiliated with medicine, even in highly biomedicalized contexts.

The Anthropology of Addiction and Treatment

Addiction treatment, as it has globalized both inside and outside of biomedical structures, is also highly pluralized, as addicted individuals worldwide have been treated in a variety of settings with numerous methods. Addiction treatment's plurality results from addiction being addressed as both a medical illness and a moral category. Anthropologists have addressed these understandings in a variety of ways. To historicize this conversation, I draw on the work of

Merrill Singer, who has eloquently organized anthropological engagements with addiction into distinct yet related frameworks of understanding (Singer 2012).

Merrill Singer defines three models through which scholars have engaged addiction since the beginning of anthropological interest in the 1970s. During the 1950's, anthropologists such as Heath discussed heavy drinking as a cultural behavior outside of developing negative connotations with alcoholism (Singer 2012; Heath 1958). While this specifically cultural focus did not deny the power of alcohol as a chemical, it did not have the problem-based focus of public health literature regarding addiction. Criticism of this approach arose, and the discipline of alcohol studies moved to a model which examined problem drinking as an activity whose meaning has changed over time and as a continuing project of globalization (Spicer 1997; Heath 1987).

Other anthropologists have examined substance abuse as a lifestyle, distinct from a culture, as drug-using communities form their own sets of behaviors, norms, and understandings, which are not generalizable (Singer 2012). These ethnographies focus on 'subcultures' whose primary purpose has become the pursuit of a substance or experience (Agar 1973; Preble and Casey 1969). In both the cultural and the lifestyle models, anthropology of the era between 1960-1980 attempted to counter the popular culture associations of drug use with psychosis, but through using a narrow focus on communities and events of drug and alcohol abuse, sometimes missed wider social connections (Singer 2012).

Using the tools created by researchers and the cultural and lifestyle models of addiction research, medical anthropology began to engage with topics involving substance abuse in the 1980s (Singer 2012). Medical anthropologists have examined addiction as a part of socially produced suffering resulting from exploitative economic practices and racial

injustice (Bourgeois and Schonberg 2009). Others have attempted to examine drug use at the moment of ingestion, keeping in mind the health disparities resulting from substance abuse, and focusing on drugs as a means of self-care (Singer 2007). The experiential model has examined the use of addictive drugs life-affirming and community producing in some settings, rather than a cause of suffering (Deleuze 2007). Furthermore, drug taking and addiction experiences are incredibly subjective and can be constitutive of larger cultural and historically created understandings of healing and the self (Garcia 2010). Medical anthropology has thus furthered the examination of cultures of drug use by focusing on specific individual cases and connecting these to situated regimes of medicine and control.

An emerging source of literature has examined the experience of rehabilitation in a variety of contexts and frameworks. Critical examinations of addiction therapies have addressed them as Foucauldian "technologies of the self," exploring the ways in which personal freedom and willpower interact with social structures of control (Valverde 1998 in Garriott and Rakheil 2015). Others have investigated how addiction reveals conceptions of the "psychological self" and the need to reference it through therapeutics such as drug counselling and 12-step methods, to narrate recovery (Carr 2010). Other work has examined how biomedical interventions were constructed based on a specific notion of the neuropsychological, brain-based self (Campbell 2011; Vrecko 2010). These therapies are seen to have specific effects, both on the ways addiction as is treated as a racialized illness and how patients form individual relationships to therapies (Hansen and Roberts 2012; Meyers 2013). Related to neurobiological understandings of the self is what Vrecko calls 'folk neurology', the understandings individuals have of themselves and their brains based on their interpretations of neuroscience. These science-based models are seen to be formative of understandings of addiction and treatments in non-biomedical

contexts (Vrecko 2006). These concepts also inform how the languages of science and medicine are co-opted by structures outside the sphere of biomedicine.

Medicalization, Partial-Medicalization, and the Pseudo-Medical

Embedded in the anthropological engagement discussed above are conceptions of addiction as both a social problem and a medical illness. Addiction is set apart from other illnesses due to its incomplete medicalization and its persistent association with notions of immorality, criminality, and control. A consequence of the partial incorporation into the structures, understandings, and regulatory mechanisms of medicine has been the development of 'pseudo-medical' therapies. These treatments incorporate vocabularies and some techniques of biomedicine without being subject to its moral and practical expectations. In assuming the power of biomedicine, these therapies enjoy a similar social role in the creation of illness and treatment in local public imaginations.

Medicalization is defined as "the process by which some aspects of human life come to be considered as medical problems, whereas before they were not considered pathological" (Maturo 2012, 122). Especially regarding 'deviant behaviors', medicalization is a process which generally transforms immoral people into sick people (Conrad and Schneider 1981). This process also involves the inclusion of a condition into medical spaces and system of regulation. It implies a level of understanding, as: "contemporary biomedicine considers life at the molecular level as a group of intelligible vital mechanisms which can be identified, isolated, manipulated, mobilized and recombined in intervention practices which are not constrained by the apparent normativity of a natural vital order" (Rose, 2007, 9). Medicalization treats bodies as atomized objects that can be completely known and treated through the creation of knowledge as stable fact, separate

from the subjectivity of culture. Medicalization also alters relationships between individual personhood and health, making health an individual's responsibility (Clarke 2009).

While many disorders have followed medicalization's linear progression from madness to illness, addiction remains partially medicalized. Efforts at medicalization have influenced the ways in which societies manage the social aspects of addiction through "differentiation and reconstitution of new populations and social forms; subjection of patients to new hygienic and treatment regimens; opening up of new professional and paraprofessional pathways and therapeutic activities, new subjectivities within reconfigured institutional spaces, treatment modalities, and community responses" (Campbell 2012, 7). Despite shifting treatment mechanisms and spaces due to medical and cultural forces, I argue that addiction has remained in a state of "incomplete medicalization" (cf. Wilton and Moreno 2012, 105). A primary reason for this has been addiction's "contested rhetoric within cycles of criminalization, medicalization, and biomedicalization" which has allowed addiction to "remain bound to sociocultural meanings and subject formations that work against the full medicalization of "drug problems" (Campbell 2012, 23). While this literature primarily addresses the ways in which the criminal justice system has been an enduring presence in responses to drug abuse, they do not focus on how this unstable definition has produced a space for private, medically-associated treatments for addiction. Below I will describe the ways medical instability interacts with Nepali government instability to create a situation in which private centers deliver treatment as violence.

The violent style of treatment given at some private centers in Nepal takes place in spaces I term 'pseudo-medical'. Anthropologists have used this terminology to discuss treatments on the periphery of biomedicine. Regarding addiction centers, there is a wide variety in the type of care they provide, but almost all derive some authority from associating with biomedical structures

through both the vocabulary and technologies they use. As drug treatment has neoliberalized in Nepal it has become a commodity rather than an object of scientific knowledge. I tread on dangerous ground in naming the therapies given at certain private centers ‘pseudo-medicine’ as a white, western-educated, medical anthropologist. In defining a foreign treatment as ‘pseudo-medicine’ I run the risk of reifying the project of biomedical hegemony and its continued effort to “medicalize everyday life” (Szasz 2007, 29). As Scheper-Hughes has remarked, medical anthropology risks becoming a tool of this process rather than a discipline which creates projects “as possible, indeed valid, alternatives to biomedical hegemony in our own society and for people very much like ourselves” (Scheper-Hughes 1990, 63). My goal in using this terminology is to critique a private industry which wears a white coat but has never been to medical school, which claims to cure but is violent, and capitalizes on vulnerability and unfamiliarity. I address private clinics as ‘pseudo-medicine’, placing them outside of the institution of biomedicine and into the space of exception, where they can make claims to biomedical understandings of the body without needing to prove them. As I will show, these claims have the potential to inflict violence and alter lives in ways which abuse ill people in the name of health.

Violence and Resistance

It is imperative for researchers to define the purpose and use precise terminology regarding the specific type of actions discussed when addressing violence in non-western contexts. Specificity is necessary to avoid sensationalizing and identifying the global south with violence, as well as the need to differentiate between the systemic violence of society and interpersonal violence at the hand of another human being. Discussing the problematics of describing and photographing violence committed within marginalized communities, Philippe Bourgois states “as representational practices they are torn between objectifying and

humanizing; exploiting and giving voice; propagandizing and documenting injustice; stigmatizing and revealing; fomenting voyeurism and promoting empathy; stereotyping and analyzing" (Bourgois and Schonberg 2009). I hope to place this analysis on the right side of this dichotomy through my choice to stress structural forces of violence which make interpersonal violence possible. When I discuss actual acts of human inflicted physical and emotional abuse, I allow those who experienced private center violence or direct witnesses to share the event in their own words.

To further contextualize the interpersonal violence I describe, I draw heavily on Galtung's concept of 'structural violence', especially as interpreted by Dr. Paul Farmer (Galtung 1969). This is a tool which allows the examination of the production of localized human misery as "acts of violence (which) are perpetrated, usually by the strong against the weak, in complex social fields" driven by "a set of historically given and, often enough, economically driven conditions" which "guarantee that violent acts will ensue" (Farmer 2003, 9). Structural violence allows us to examine things like addiction and mistreatment as larger aspects of historically deep and culturally specific elements of marginalization, helping connect the everyday violence of dehumanization with the exceptional violence of things like torture as co-constitutive. They allow for the re-assertion of local histories where they have been erased to justify marginalizing practices (Farmer 2004).

The denial of marginalized peoples' powerlessness in cycles of oppression accompanies these historically deep and intertwined discussions of exceptional and everyday violence. In the narratives I received from informants about treatment and violence I was reminded that individuals do not experience addiction as a linear motion from sick to well, nor as inexorable decline, but as a trajectory. This concept is useful as "trajectory signals a shift away from a

synchronic focus on symptoms or markers toward a diachronic one on individuals going through changes and the relationship between individual experiences, life-course events, and environmental processes" (Garriott and Raikhel 2013, 9). Other authors have examined experiences of drastic life change, such as childbirth, as projects. Brunson (2016) argues projects "imply actors who have desires, actions that have constraints, and an extended temporal aspect, for projects do not happen all at once. Projects are designed, abandoned, constructed, delayed, revised, interrupted, and remodeled over time" (Brunson 2016, 114). Recovering from addiction is a similarly nonlinear process, as the desire to change patterns of ingestion interacts with other forces which determine how people in a given place live their lives.

Mistreatment in the field of drug rehabilitation is a growing concern among nations wishing to rid themselves of problematic drug users and is not unique to Nepal. The Campaign to End Torture in Health Care released two reports in 2011 detailing cases from around the world in which care providers used violence in the name of drug rehabilitation treatment. Many of the narratives of care were similar to what I encountered in Nepal: That users' parents', who believed their children could be cured through the methods of loosely regulated space of care, placed them in centers against their will (WHO 2010). Globally, users are speaking out about mistreatment they have endured in such centers. Recently, the Nepali TV show "*Sīdhā Kurā Janatā Sañga*" (Direct Conversation with the Public) aired a special discussing an investigative report where the lead reporter visited a rehabilitation center from which 13 men had recently escaped. Inside the center he encountered deplorable conditions where caregivers forced patients to collect bedbugs and drink their own urine. This report led to the Asian Network of People who Use Drugs (ANPUD) to call on the UNODC and UNAIDS to openly denounce and work towards the closure of private centers failing to operate up to the international standard (ANPUD 2018). The

marriage of violence and drug rehabilitation is sadly not limited to a few problematic institutions, it is a widespread assault on the dignity of substance users worldwide, as shown by the need for ANPUD to publicly declare that "People do not lose their human rights simply because they use or sell drugs" (ANPUD). South Asian governments' focus on regulatory efforts through War on Drugs style crackdowns shows that the relationship between drug treatment and punishment has become naturalized.

Treating Drug Abuse in Nepal

While injecting practices were uncommon in Nepal prior to 1990, intravenous drug use and its accompanying health concerns have increased in urban areas since the late 1990s (Ojha et al. 2014). The WHO believes there are between 17,000-24,000 injecting drug users in the country, but the problem may be more severe as Nepali health statistics are notoriously difficult to collect and verify (WHO 2010; Justice 1989). The increasing prevalence of drug abuse has caused localized HIV epidemics within the IDU community and has been blamed for numerous other social issues in urban areas (Sinhas 2008). In response to these concerns, the Nepali government has created a Drug Control Section within the Ministry of Home Affairs (MOHA) with the intent of reducing drug supply and demand.

Despite government provision of detoxification and Opioid Substitution Therapy (OST) at teaching hospitals and centers throughout the country, many Nepali drug users are treated at Non-Governmental Organizations (NGOs) which are termed 'strategic partners' (Sinhas 2008). These centers are becoming increasingly prevalent in urban areas as drug abuse and knowledge of its treatments have become more available. There is a huge variety in the type of treatment that private centers provide in Nepal. Some follow standard psychiatric evidence-based therapies, which psychologists at Tribhuvan University Teaching Hospital advocate for and

represent the standard in Nepali drug abuse care. Others preach specific versions of what drug addiction and 'addicts' are to distinguish their treatment mechanism. This loosely regulated industry incorporates centers which actively do harm to those placed inside. Because of a lack of governmental regulation and a specific creation of addiction as a curable behavioral disorder, violence is permitted to be given as treatment for those labeled 'addict' in urban Nepal.

In examining the privatization of drug abuse treatment in Nepal, this study engages with larger trends of neoliberalization in Nepali healthcare. A primary area of interest for scholars concerned with the privatization of healthcare in Nepal has been the loose regulation and massive proliferation of private medical schools (Holden 2005; Shankar 2011). Scholars blame the lack of government spending in the healthcare sector, the loose regulation, and neoliberal economic policies for the current era of medical privatization in Nepal (Mishra and Acharya 2013). In the case of drug rehabilitation, private industry is held responsible for creating standards and practices for managing addiction. Market concerns govern the ways in which private centers undertake this task, with centers using dubious statistics and advertising campaigns serving to promote their business and advocate for their specific definition of addiction and treatment. Private centers participating in the neoliberal marketplace create an environment in which care can be provided in a variety of forms. In this exchange, private centers and addicted persons' parents negotiate care, as parents are usually responsible for placing their children in treatment.

Social scientists have used the concept of neoliberalism to describe a myriad of institutional arrangements. While some believe the ubiquity of the term neoliberalism makes this concept obsolete and obscures the anthropological vision of the world in the 21st century, I believe the term is still useful when situated properly amongst localized structures which

determine the flows of goods and services within a situated context (Eriksen et. al 2015; Ganti 2014). In Nepal, where government services are sometimes supplanted by over forty thousand NGOs and some scholars have deemed the state an "NGOdom," examinations of how the state manages its social responsibilities are necessary (Citrin et al. 2018; Shah 2002, 156). Regarding healthcare, the proliferation of many venues of private, public, and 'traditional' forms of healing create a situation in which patients must "navigate the diagnostic maze" (Harper 2014 in Citrin et al. 2018). Of central importance in this discussion is the concept of local accountability. Private institutions' ability to determine the effectiveness of their treatment in an insular manner makes this a pressing issue. In other words, "Questions about who evaluates the evaluators, and who audits the auditors, are seldom asked" (Adams 2013, 81). Concerning the subject of privatized drug rehabilitation, questions of accountability and data become increasingly important and complex, as the reliability of patients themselves is questioned through the moralization of addiction as a 'behavioral illness'.

This paper synthesizes conceptions of moral propriety, economics, and governance, to examine how addiction treatment has come into being, is regulated, and is experienced by those whom it claims to help. It will argue that in Nepal, the incomplete medicalization of addiction allows definitions of 'addiction' and 'addict' to become commodities in a neoliberal marketplace of care. This marketplace allows notions of curative behavioral therapy to overlay those of chronic illness, forming a hybrid in which substance users are dangerous and immoral, while also being ill. The neoliberalization of biopower brings about new ways in which violence can masquerade as medicine within the exceptional space of the private clinic.

Methods and Access

Methodologically, this project draws heavily on the work of Angela Garcia and Harper et al. Garcia (2010) conducted fieldwork at a rehabilitation clinic in New Mexico and used her role as a care provider as a means of conducting participant observation and recruiting interview subjects. This method is a safe and legal way to engage in an illicit market. It also allows for the incorporation of biomedicine and the therapeutic apparatus in ways that studies situated on the street do not (Garcia 2010). Harper et al.'s work has addressed the context of public health projects in Nepal. Their (2011) examination of the ways in which local Nepali pharmaceutical manufacturers evaded government regulation is notable to this project for its methods of interview recruitment. Harper et al. recruits and observes in the waiting rooms of hospitals and clinics, where local pharmaceutical representatives market locally produced pills. He also engages policymakers to determine the origins and limitations of substance regulation (Harper et al. 2011). While I did not recruit from waiting rooms, I found their methodology of interviewing individuals involved in the production and consumption of therapies extremely useful in understanding the distance between bureaucratic language describing state activities and actual patient experiences of these same actions as everyday realities.

I collected the data upon which this study is based from the period of late May 2018 to early August 2018. During this period, I was helped immensely by connections provided by Dr. Thapa and Dr. Acharya, two professors from a renowned journalism program in Kathmandu. Dr. Acharya was instrumental in allowing me to gain access into private rehabilitation centers and government offices for tours and interviews. Through Dr. Thapa's connections, I was also able to meet with administrators from the TU teaching hospital, where I was introduced to Dr. Sagun, the specialist in charge of the OST facility affiliated with TU teaching hospital. He introduced

me to his staff, where I met Manoj, and invited me to visit the OST center, where I did most of my interviewing.

While my study's initial goal was to provide a snapshot of many types of rehabilitation care in Kathmandu, I changed my approach once it became clear that violent acts were being committed in many private centers. I began to spend a lot of time with Manoj at the OST center in his office. The OST center was not just a place where people received Buprenorphine and Methadone, it was a social hub for the formerly addicted community to meet, have tea, and work on advancing the political cause of people who use drugs. With the help of Manoj and Karma, another worker at the OST clinic, I was able to interview recovered individuals about their experiences with private rehabilitation. Accompanying these more formal interviews were informal conversations over tea and snacks in the shopping district adjacent to the OST center. The conversations over tea also offered insight into the family lives and relationship of men struggling with addiction. The center became a place where I collected data about the experience of being rehabilitated at several private centers in Nepal, as I spent many weekends and afternoons there conducting interviews and spending time with the men who worked there.

Manoj and the other men working the center treat their job with utmost sincerity, they believe the service they provide gives users an alternative to unregulated private treatment. When I asked about how a private center might start Manoj told me: "So you get maybe 75 people in one house! How are they staying? How are they sleeping? So I feel bad for these people, they are also men, they are our brothers." It was clear that for Manoj and the other men working in OST the type of work they did was more than a means of employment, it represented a sense of duty to similarly ill human beings. Through Manoj's connections, I was able to meet and interview many young men about their experiences in private centers and their thoughts on methadone

maintenance. Some interviews would last no more than ten minutes, the respondents having little to say about their experiences beyond just stating what was good and bad. Others, like Sunil's, were 90-minute affairs punctuated by stories of parties in the mountains and running from the police. After the center closed, many men would hang out at a nearby tea stall where, when invited, I would join them. Aside from the nuts and bolts of treatment, two main themes which emerged from these interviews and conversations were the government, usually in the form of police, and violence. From these discussions a sense of anger and an activist voice emerged; these were men upset with their government for having outsourced their care to private industry, an industry that was largely predicated on dehumanizing and causing them harm.

One of the main centers Dr. Acharya helped me gain access to goes under the pseudonym of 'Drug Care Nepal'. While this name is imaginary, the interviews and observations I collected at this center are genuine. At DCN I was able to tour the facility, have extensive interviews with the owners and staff, as well as observe a staff meeting. I visited DCN for three long visits; once with Dr. Acharya, and twice by myself. While inside of DCN a staff member always accompanied me, which meant I could not see the entirety of the clinical space and what I did see was curated by those who ran the center. To get a fuller picture of what occurred within DCN, I combine accounts of employees discussing what they claim to do, with former patients recollecting the actuality of the treatment experience. This allowed me to connect the violence described by former patients with the treatment that clinic officers narrated.

As final note on the treatment of gender and caste in this piece, I would like to discuss the limitations of these findings. Drug abuse is a particularly stigmatized practice for women in urban Nepal, making women more vulnerable to social ostracization and infections related to drug abuse (Ghemire et al. 2013). Women are almost always treated in separate facilities than

men and I was unable to access these facilities during the period of my research. While addiction is considered a men's problem in much of the literature, the attached stigma of female intoxication in Nepal implies that female addiction is likely a much larger problem than reflected in many government statistics (Shrestha 1992). Additionally, some may find my lack of discussion of caste in this piece striking, as many scholars understand that caste issues persistently overlay other problems of marginalization in Nepal (Gurung 2009). While caste may very well play a role in the violence occurring during rehabilitation experiences, I was unable to determine what that relationship may be due to my inability to systematically record interactions between staff and those they cared for and their respective castes. This missing data as well as my low sample size makes me unable to generalize about the role of caste in enrolling in private treatment programs or the intersubjective relations of staff and residents. Addiction appeared to be an additional layer of marginality that may be added onto caste. More research is needed on gender and caste categories in relation to drug rehabilitation.

Thesis Organization

Chapter one discusses the ways in which the Foucauldian conception of state biopower has interacted with the governance of drug use in both the contexts of the United States of America and Nepal (Foucault 1995). To explain these associations, this chapter will draw on the history of addiction treatment, from its beginnings as a moral failing to its partial medicalization, treated in medical, non-medical, and juridical spaces. It will explain the relationship between the persistence of the carceral system in treatment and addiction's association with punishment. In explaining how biopower is expressed in the US and Nepal, I argue that in the US, biopower is expressed as a single agenda operationalized through many appendages, all representative of state goals. In contrast, the Nepali state exercises biopower through privatization and

multiplicity, as it is both invisible and visible in ways which it ensures that a certain status quo is created and maintained.

Chapter two futhers the concept of the multiplicitous state, showing how biopower is exercised through enabling the creation of private drug rehabilitation centers as spaces of exception. This section draws heavily on the work of Giorgio Agamben as it explains the ability of private centers to operate legally while breaking the laws of the state. This is enabled by the creation of a lawless minority, in this case, young drug users (Agamben 2005). In the Nepali case, the Ministry of Home Affairs writes private centers like DCN into their response to drug addiction, using them as a manifestation of the sovereign state, while simultaneously lacking the regulatory mechanism to ensure that the progressive standards of the ministry are upheld. This situation complicates Agamben and is better explained by Akhil Gupta's discussion of bureaucratic "red tape," in which governmental indifference allows cycles of abuse to endure (Gupta 2012). Gupta's analysis allows us to frame things like the national police involvement with private centers as fragmented aspects of status quo maintenance. It also allows us to peer behind the thin veneer of the multiplicitous state's protocols and governance to analyze processes which allow individuals to profit from creating human misery.

Chapter three discusses the relationship between private center narratives of addiction, espoused through massive advertising budgets, and the marginalization of Nepali addicts. Focusing on illness and treatment narratives, private centers create addiction as a moral and behavioral disorder that is curable with a specifically nonmedical set of techniques (Kleinman 1988). This narrative follows specifically Nepali tropes involving youth, danger, and the need for distance from morally polluting people and activities (Liechty 2003). These narratives work to deprive addicted individuals of the right to make claims to personal wellbeing on the state, or

biological citizenship (Das and Randeria 2015; Rose and Novas 2005). Similar processes associate the label of addiction with exclusion from the Nepali moral community, a concept which draws on Briggs's description of sanitary citizenship. This term describes the process through which claims to moral personhood are tied to an amalgamation of public health discourse, political agenda, and racial politics in identifying a specific medical relationship to the body (Briggs 2003). It also shows the ways the creators of this narrative attempt to divert authority away from the burgeoning Nepali psychiatric sector, forming a niche for care on the periphery of Nepali medicine, where biomedical regulatory measures are absent.

Chapter four engages the actuality of private center violence as a set of acts imbued with political and moral meaning. It engages the literature discussing the overlaying of treatment and punishment before showing the everyday and exceptional nature of violence in this context. This section draws heavily on addiction survivors' accounts of the ways in which they encountered and, in some cases, resisted violence. As individuals whose citizenship has been stripped through being identified as immoral subjects, concepts of violence, torture, and therapeutics are blurred in the creation of sober bodies. I frame this as a consequence of an exceptional space treating individuals who are noncitizens, naturalizing the relationship between punishment and medicine. Private center employees play upon medical notions of curative power to establish control over addicted bodies, giving them the right to exercise biopower in the context of harmful medicine.

While this piece engages heavily with theories of illness, systems of economics, and the state, it is drawn from lives which have been situated for brief and extended periods of time in situations of extreme suffering. The pain, desperation, and hopelessness one feels when sent to a private center by one's family, the most robust support structure for many urban Nepalis, should not be overshadowed by these theoretical discussions. Rather, this work is intended to reveal the

political and social workings which make torture and violence within treatment contexts possible; the ways in which human bodies become so marked by immorality that maintaining communal moral order requires their internment and suffering. I was humbled to work among men who had survived trajectories of illness which could easily have ended their lives, men who had decided to resist dominant narratives of decline and death, and who against forms of social and economic dominance, imagined an otherwise.

Chapter 2. The State as a Multiplicity: Drug Use Prevention in Nepal

"I went to the rehabilitation center more than 20 times, but it did not work. But methadone worked. Now I am clean, I don't use, only cigarettes, milk tea, and coffee!" On my first day at the Opioid Substitution Treatment (OST) center, Manoj and I sat in an office in the back, drinking tea while I tried to explain the purpose of my project. Throughout my time at the clinic, Manoj was always dressed in brightly colored shirts or a tailored denim jacket; his sense of style threw off my perception of his age, and he laughed when I told him I thought he was just thirty. Manoj's life has been marked by drug abuse since he began using in the 1980's. Despite his strong desire to remain sober, he bounced between states of sobriety, relapse, and treatment until 5 years ago. He remains optimistic about his current period of sobriety but understands its fragility: "I am clean for five years, but I don't know about tomorrow. Today I'll take nothing, but tomorrow?" Manoj now works in an OST clinic, acting as a counselor, a supervisor, and an outreach worker. His fervent energy and unwavering enthusiasm usually drive him to take on all three roles in day.

Manoj has survived multiple eras of opiate use and treatment in Kathmandu. Survival is not an exaggeration in this chronology, and reflects the unstable atmosphere surrounding the use of opiates in Kathmandu. While conditions have generally improved, Dr. Sagun once told me that even today "It is hard to survive drug addiction in Nepal. In a low-income country like Nepal there is nobody for you." The history of drug addiction treatment in Nepal has been marked by the nearly unregulated development of a healthcare system, inconsistent NGO involvement, and shifting stigma. The transitions from the creation of moral category, to criminalization, to incomplete medicalization, both mirror and diverge from the development of state and biomedical responses to addiction in the United States. While basic conceptions of the

relationship between addiction and biopower are similar, a partial consequence of the globalization of the War on Drugs, the ways in which bodily governance is undertaken in US and Nepali contexts are divergent.

Concerning the exercise of biopower, one highly consequential difference in the evolution drug treatment in Nepal and the United States are the separate paths of privatization and government centralization. In the case of Nepal, addiction treatment has become part of the privatization of the health sector. Private clinics fill a void between services provided by limited government and INGO services that were once the realm of NGOs concerned with the auxiliary effects of intravenous drug use and small government projects. Responsibility for providing care for those addicted to drugs has shifted between numerous government agencies and non-governmental actors from the 1980s to the present. This instability created a multiplicitous state, whose presence and visibility allows for the simultaneous dialogue of progressive treatment methods and the creation of spaces in which violent means can be used as treatment. The privatization of treatment as a part of the state response to addiction effectively places biopower on the neoliberal marketplace. Instead of a centralized biopower exerted across multiple state appendages, the Nepali situation privatizes the administration of biopower as a partially medicalized treatment which creates docile bodies.

Biopower, Foucault's famous term describing the ability of states to control their populations through acts of discipline and punishment has been expanded upon in the realm of healthcare provision, especially as it relates to globalized standards of individual health (Foucault 1994). However, the administration of biopower is complexified in states like Nepal where “scientific sovereignty replaces the state, in Foucault's sense as a set of power relations that act on human biology, with a leaderless, difficult to describe coalition of industry,

multilateral, and nongovernmental organizations that references health itself as a justification for its power" (Samsky 2012, 312). Addiction treatment in Nepal developed in the private sector alongside local and international NGOs efforts. These early organizations focused their efforts on infections resulting from injecting drugs. However, as addiction interventions began directly addressing the disease of addiction itself, treatment shifted to entities which share the label of 'NGO' while operating as for-profit businesses. The development of addiction treatment as a health response thus allows biopower to be exercised through entities recognized by the Nepali government, but not under its direct control or supervision.

The United States has addressed addiction as a continued project of bodily control, exercised through both juridical and biomedical appendages (Keane 2009). This has been shown through the transition from behavioral models of addiction to medical ones. While the acceptance of the medical model in some spheres has expanded the ways in which the state addresses addiction, both biomedical and corrective state projects aim to create normal and docile citizens (Bourgois 2000). The project of normalcy and a political climate requiring policymakers to be 'tough on crime' has allowed the behavioral model of addiction to persist (Courtwright 2010). The persistence of conservative attitudes towards drug use has resulted in an environment where addicted persons generally move from juridical to medical spaces of control as addicted bodies are treated by intensive state presence rather than the state multiplicity and privatization, which characterize the Nepali response to addiction.

Despite the different approaches to the state governance of addicted bodies, Nepali and US regimes of control are linked through the globalization of the US War on Drugs. This connection can be seen through the lens of transnational criminology, which allows us to examine "the creation of transnational legal regimes and enforcement strategies and how

decisions taken in one place impact far distant localities" (Bowling 2011, 3). Regarding the connections between US international presence and the criminalization of drug use, examining legal and moral controls of substance abuse in the US and how they have been disseminated is crucial. This chapter will show that when the tenets of biopower applied to drug abuse are internationalized, the types of governance they produce creates unexpected and often undesirable situations, referred to by some as "the globalization of harm production" (Bowling 2011, 1).

The Birth of a Marketplace: Three Stages

Opiate consumption and addiction are relatively new phenomena as medicalized and moralized categories in Nepal. The ways in which private clinics, the primary addiction treatment locale, have become spaces of exception is intimately intertwined with the history of drug use and responses, which have created a neoliberal marketplace for rehabilitative care. In this narration, foreign problems become local, social problems become partially medical, and treatments become commodities. Most consequentially, biopower, as expressed through globalized regimes of substance abuse control, becomes exercised by private entities, displacing both state and medical sovereignty with new forms of treatment and control.

The Hippie Era

Many accounts of drug use in Nepal begin with a discussion of the historical use of marijuana or ganja as a long-standing part of Hindu ritual tradition (Sinhas 2008). However, the timeline of pharmaceutical opiate abuse and treatment began with the formal opening of Nepal's borders. Nepal opened to tourism in 1951 and after a brief period of upper-class English patronage, became a destination for countercultural seekers of the 1960s and 70s (Liechty 2017). While these travelers were mostly interested in hashish, some hippies and US army personnel on leave took advantage of cheap, medical-grade heroin that was available through British

pharmacies in Kathmandu. Even during this early stage, the use of opiates was more associated with pharmaceuticals in the form of 'liquid heroin' and medical grade morphine than illicit "brown sugar" heroin coming from the Golden Triangle. While opiate use was not in the mainstream, those who did use were highly visible, which contributed to the perception that addiction was an outsider's problem (Liechty 2017).

As Cold War relations between China and the US began to thaw, Nepal's foreign aid, which it had been receiving from the United States, was put in a precarious situation. King Birendra expressed the desire to rebrand Nepal as a destination for 'adventure tourism' rather than a place for inexpensive and legal hashish. This coupled with pressure from the Nixon administration internationalizing their War on Drugs, leading King Birendra to illegalize hashish and all other drugs in 1972 (Liechty 2017). Prime Minister Kirti Nidhi Bista stated that this was imperative due to the "harmful effects of narcotic drugs on the younger generation and in recognition of international responsibilities" (in Liechty 2017, 278-279). After affiliating with the UNODC in 1973, Nepal had officially joined the international community in condemning and criminalizing drug use.

The pressure to become a prohibition state like the US was largely the result of the US conceptualization of Nepal as a transit locale for drugs like hashish and heroin. Typically, policy responses aimed to reduce the sale and consumption of drugs are usually separated into supply and demand reduction. Wodak et al. argue that while War on Drugs measures have affected the supply and demand in immediate locale of policymaking, in this case the global north, they have the opposite effect in the global south, where the substances are typically manufactured and transported. As the drug trade becomes more perilous and profitable, and conditions in production and transit regions worsen, drug abuse and its consequences become much more

severe. Thus, the incorporation of Nepal into the US project of supply reduction created a situation in which

> More dangerous drugs and more hazardous routes of administration and the increasingly serious consequences of drug injecting for individuals and communities has occurred while global prohibition has intensified and free market economic policies are implemented almost universally (Wodak et al. 2004, 800).

The incorporation of Nepal into the War on Drugs cemented the relationship between criminality, punishment, and drug use while simultaneously developing new ways in which economies of care are enacted. Both factors had catastrophic implications for drug users in Nepal.

The Injection Era

While scholars dispute whether the illegalization of hashish caused the opiate problem to worsen, by 1985 there were 12,000 estimated local cases of heroin addiction in Nepal (Reid and Costigan 2002). The opiates distributed during the Hippie Era in pharmacies were mainly bioequivalent to 'street drugs' in their purity, but soon cheaper and equally powerful synthetics would enter the scene. By the 1980s the Indian pharmaceutical production sector began to mature and distribute its products in Nepali markets. During the 1980s and into the 1990s, users began to shift from oral and nasal ingestion of Afghani and Pakistani heroin to injecting synthetic pharmaceuticals. Scholars attribute this shift to the types of pharmaceuticals available at certain periods. An Indian made, injectable form of Buprenorphine named Tidijesic became available at more inexpensive prices than illicit brown sugar heroin and other intoxicants available in pharmacies. As a result, many drug users transitioned to injecting rather than paying higher prices for other 'safer' sources of opiates (Sinhas 2008). Apart from pioneering caregivers like Father Gaffney, the government response to drug use during the 1980s was purely criminalization. However, in 1994 the Ministry of Health and the Ministry of Home Affairs

began a methadone maintenance program to couple with their Nixon-inspired supply reduction efforts. This program was the first of its kind in South Asia and operated alongside other harm reduction measures such as needle exchanges (Ambekar et al. 2013). The methadone maintenance program represented a shift in the conception of drug use in Nepal as government enacted programs began to include demand control.

Despite the progressive shift in Nepali drug policy at the turn of the century, a lack of knowledge regarding safe injecting practices and stigma surrounding drug use made needle sharing a common practice among opiate users in Nepal. In 2002 an estimated 68% of all hard drug users in Nepal had become HIV positive (Sinhas 2008). This period was the peak of the global response to HIV, especially in the INGO sector. Nepal was incorporated into this massive effort and by 2001 there were over 1,500 NGOs specifically working with HIV reduction in Nepal. Although the HIV epidemic was largely confined to intravenous drug users, these NGO's efforts were primarily focused on treating HIV rather than addressing drug abuse (Kheregal 2001). The government was split in its reaction to this crisis. While the Ministry of Health advocated for needle exchange programs and the provision of methadone, "The main focus in the Ministry of Home Affairs is on demand reduction and they do not agree with the implementation of NSP (Needle and Syringe Programs)" (Reid and Costigan 2002). This was shown through the closure of government-provided methadone treatment in 2002, the peak of the HIV crisis for intravenous drug users. However, with the help of ARV provision funded by the Global Fund, harm reduction efforts undertaken by NGOs, and tireless advocacy from the Nepali drug using community, HIV rates began to gradually decline.

A German publication discussing its role in Opioid Substitution Therapy (OST, a version of methadone maintenance which incorporates Buprenorphine) provision in Kathmandu states:

“Official opposition to harm reduction approaches in Nepal was never absolute, and the government’s practice of outsourcing many programmes and activities to civil society actors created a certain amount of space for innovative, politically-sensitive approaches to be tested out at a small scale” (German Health Practice Collection, 2015). The experimental atmosphere created through the lack of governmental regulation and the needs of the health crisis allowed space for a variety of treatment spaces to emerge. This era opened the door for the possibility of a private rehabilitation industry.

The unregulated environment surrounding drug treatment also allowed for the creation of the OST center, where I conducted most of my interviews. While OST provides some users with the opportunity to stop using opiates, the psychologists running the program view it as another form of harm reduction, meaning it attempts to mitigate the ill effects of drug use rather than enforcing a zero-tolerance policy (Single 1995). OST is a continued and relatively successful project aimed to minimize the transmission of blood borne disease among the intravenous drug user (IDU) population. While HIV transmission remains a risk for drug users in Nepal, after the intensification of harm reduction efforts in the early 2000’s, it was no longer at crisis level and infection rates began to fall in 2007. Before the boom in private center creation, many drug related interventions were “HIV centric, as they were funded by HIV related donors...harm reduction programs funded by donor communities have remained the major focus of the national programs, and too are focusing on IDUs (intravenous drug users)” (Sinhas 2008, 93-94). However, the treatment for drug addiction itself was lacking, with a majority of INGO and government resources going toward harm reduction efforts, and with these efforts being unstable do to their reliance on donors. “Strategic partners argue that every intervention should not boil down to ‘harm reduction’ and that a large portion of needs will go uncared for if the government

only keeps occupied with HR strategies" (Sinhas 2008, 95). Government and NGO response thus left open a vacuum of potential for care provision in Nepal. During this time, drug use was understood through its side effects, mainly HIV, which meant that those attempting to treat drug addiction as an illness could create treatment regimens within a new marketplace for care.

The Private Era

Following structural adjustment in the 1990s, Nepal's medical sector began to privatize rapidly. This is perhaps best shown through the ways in which medical education has developed. Responding to the growing needs of young Nepalis for technical skills, private medical education began to emerge as a major source of instruction. Private education allowed Nepali medical students to stay in the country for their education, increased the amount of services available, and created jobs for trained medical physicians. However, in the words of Adhikari, "such institutions have to function as viable commercial enterprises rather than as institutions with a purely social mission" (Adhikari 2006, 59). As a result, "the general hurry to get approval from different government agencies and the professional council, and to admit students even when the basic infrastructure is not in place, is a feature very commonly associated with private institutions" (Adhikari 2006, 62). Poor regulatory mechanisms allow a wide array of institutions to be established with limited governmental oversight to ensure that quality care is being provided. Private health services are generally perceived to be preferable to government care. However, scholars state that this is a "misconception among the people that the service provided by the private institutions are of high standards, and much safer than the public services" as "there is a chance of a lack of quality care, misconduct by the health care practitioners and inaccessibility of the wide range of services in the private institutions" (Mishra and Acharya 2013, 10).

While reviews of global health policy explain the neoliberalization of healthcare as a decentralization of once-functional government services through partnering with private entities, the Nepali situation is noteworthy in the way that it has been unregulated and diffuse from its inception (McGregor 2001). Advocates of healthcare neoliberalization utilize free market ideology, in which consumers benefit from theoretically cheaper healthcare which does not rely on taxpayer funding. However, decentralizing healthcare corresponds with reducing spending in state provided health services and limits local governments' ability to intervene in a now largely unregulated marketplace, harming consumer wellbeing as the welfare state shrinks (Labonte 1998). Healthcare in Nepal has always been plural, in the sense that many healing traditions have and continue to be used to heal. Faith-based and Ayurvedic traditions of healing have mixed with allopathic medicine, introduced by Christian missionaries during the Malla Period. (Dixit 1999). State-provided healthcare, and the incursion of biomedicine as a state-provided activity began with the overthrow of the exploitative Rana Dynasty in 1951, during which the US conducted development projects with the goal of countering the growth of communism in the region. This included large-scale health projects, like the Malaria eradication program that began in 1958, which also intended to demonstrate the value of western aid and biomedicine. The succeeding Panchayat government sought to demonstrate its worth through development projects to further its project of national consolidation. These modest development projects became much more ambitious after the 1990 constitution was recognized and INGOs became "proxies for civil society" (Ismail 2017, 5). While in the 1990's Nepali "healthcare delivery (was) by and large a government affair," the social welfare it provided was limited, leaving the door open for the continued influx of NGOs (Dixit in Citrin et.al. 2018, 101).

While global health discourse describes NGOs as being generally motivated by humanitarian concerns, many operate with a profit motive. NGOs in Nepal are regulated by the Social Services National Co-ordinating Council, which serves as an umbrella organization which seeks to promote coordination between NGOs and the government. Despite the existence of organizations meant to monitor, their capacity is limited and some NGOs operate "as for-profit providers in practice" (Gilson et.al 1994, 14). In this unregulated climate, NGOs which are depicted to promote humanitarian causes, can instead be for-profit entities operating under label of "NGO." These providers capitalize from the unregulated atmosphere and gain social capital through being called an "NGO." Thus, Nepali healthcare has not decentralized, like other countries with neoliberalzed healthcare systems; it has grown out of a continued atmosphere of outside influence and a lack of regulation.

The privatization of healthcare has also become an increasingly important aspect of care provision. In 2010, two thirds of all hospital beds and 60% of all doctors were in private facilities. Accompanying direct privatization, "public-private partnerships" (PPP) have become increasingly utilized, differing from NGOs because they aim to eventually increase state capacity to improve public health institutions (Citrin et al. 2018). Drug treatment in Nepal differs from private and public medical enterprise, as well as PPPs. Private treatment centers are not officially "privatized" since they are run as NGOs and monitored as such by the Ministry of Home Affairs. The period following the response to the early 2000s HIV outbreak up to the present can be characterized as the gradual privatization of drug rehabilitation.

The Nepali government's choice to include private centers in the national response to drug abuse theoretically expanded the modalities of treatment available in Nepal. However, as has been noted by other scholars, many NGOs involved in healthcare provision are operating as

for-profit institutions. Especially in contexts like Nepal, where NGO care provision is a large part of the health sector, governmental capacity to regulate at local and national levels is crucial (Gilson et al. 2004). Nepal lacks this regulatory infrastructure. Instead, the chronology presented above has resulted in a market for addiction treatment which operates as a surrogate function for the state. The creation of normalized bodies, a process which will be discussed below, is thus undertaken by both the state itself and by private providers of care, placing their treatment on the neoliberal marketplace.

From "Disease of the Will" to "Chronic Illness"

As explained above, the Nepali response to drug abuse and criminalization is intimately tied to incomplete medicalization of drug abuse in the US. The ways in which biopower and the creation of docile and normal bodies has intersected with medical structures has created addiction as a hybrid condition of criminality and chronic illness. The incompleteness of addiction medicalization has drastic consequences for how addiction is treated in Nepal and the US. While biomedical structures have always involved some form of control, addiction's relationship with the judicial branch of state power makes this association have unique consequences for individuals who use drugs. Although biopower is exercised directly through the state in the US, and indirectly, through private actors in Nepal, the outcomes of incomplete medicalization are similar: addicted bodies are interned and become projects of normalcy creation.

In North America responses to addiction have been associated with bodily control since the initial conception of overconsumption as a behavioral flaw. Conceptions of drug use and proper governance have been tied to issues of medicalization, racism, and conceptions of immorality. While many medically recognized illnesses have stigma attached to them, the terms

"addiction" and "addict" are particularly loaded with moral baggage. The specific nature of this cargo is diverse, depending on where the addict is situated. The influence of global psychiatrics, made possible through the movement toward biomedical hegemony, and the international aid complex has globally disseminated the disease model of addiction: that it is a chronic, relapsing brain disease (NIDA 2015). However, this definition is one among many models of addiction which continue to be used to develop treatments, as shown through the Alcoholics Anonymous literature shifting from treating the soul to treating the brain (Vrecko 2006). The background of the behavioral and disease models of addiction explains the ways in which the incomplete medicalization of addiction allows them to both remain viable frameworks of treatment.

Early conceptualizations of addiction beginning in the 1780's depicted a person's inability to control the amount they drank as a character flaw resulting from moral weakness. The behavioral model of addiction is constructed as a "disease of the will," where the opposing categories of "desire" and "will" represent the forces of the various stimuli which confront a person daily. A person's ability to govern the consumption of objects of desire is defined as 'willpower' and when they are unable to govern the body sufficiently, they are labeled as weak-willed because "the ability to suppress the desire to drink is crucial for individual moral and physical health and well as for national success" (Valverde 1998, 96). This conception was championed by Dr. Benjamin Rush, the father of American psychiatry, and reflected the Calvinist religious conception of willpower. As the status of alcohol swayed between legal and illegal in response to a variety of moral panics, the consumption of numerous other illicit intoxicants became similarly moralized. While the behavioral model provides "cures" to strengthen the will, the primary means of dealing with substance dependent

individuals (Dackis and O'Brien 2005). The idea that the will is a muscle that can be flexed laid the groundwork for abstinence-only policies and 'just say no' approaches which stressed the idea of self-governance and responsibility for the individual body (Valverde 1998).

Beginning in the 1930s, neuroscientific research began to change attitudes towards addiction by locating the disease in the brain. Specifically, scientists became interested in the ways in which the functions of the brain were affected by long-term drug use (Courtwright 2010). This conceptualization was a part of a larger movement in psychoanalytic psychiatry, locating personhood in the "brain-based self" which "provided a unified framework for a problem-based field in conceptual disarray" (Campbell 2011, 194;200). The emphasis placed on uncontrollable facets of the complex human brain implied that the location of drug treatment was not in the soul of the addicted person, but in the brain, effectively placing addiction treatment in the realm of neuromedicine. This transition is typical of narrations of medicalization, in which a social ill is recreated as a treatable illness through science's processual march towards absolute knowledge. Addiction's medicalization is best represented through the ability to visually demonstrate the difference between addicted and non-addicted brains via neuro-imaging technologies (Campbell 2011). Thus, the case was made that those with substance use disorder should be treated by mental health professionals and neurologists, rather than by the juridical tools of the state. The chair of the American National Institute on Drug Abuse, Alan Lesher, stated in a 1997 paper that moving forward, the NIDA would adopt the definition of addiction as "a chronic and relapsing brain disease," which has guided the scientific community's approach to addiction since (Lesher 1997, 45-47).

Despite the seamlessness of the transition from moral defect to medical disorder, the conceptualization of addiction as a disease of the will continues to haunt both treatments aimed

at rehabilitation and many forms of criminal justice. Scholars have lamented the continued inability of North American popular culture to conceptualize addiction as a neurological disorder rather than a character flaw (Dackis and O'Brian 2005). While social understandings of illness change slowly, political and economic systems are theoretically more malleable to scientific findings. Politically, disease models have not led to widespread policy changes because of the focus on drug supply reduction, undertaken by law enforcement personnel. Although not stated explicitly, the NIDA definition of addiction rationalized this course of action through its conceptualization of the addicted brain as unalterably changed, meaning that it was more effective to focus on preventing drug abuse rather than destigmatizing users with an already altered psyche. Since the Nixon era of the 'War on Drugs' politicians have been wary of appearing soft on this issue because it would imply that they are generally soft on crime. These factors explain the US's slow adoption of many harm reduction methods that were widely hailed as successful in reducing intravenous diseases (Courtwright 2010).

Economically, while one would expect scientific special interest groups and pharmaceutical lobbies to intervene given that they had produced effective craving-reduction drugs, the mass incarceration of drug users did not affect that ability of clinicians to prescribe mood altering drugs. The codified criminalization of drug use resulting from the incomplete medicalization of addiction both made medical and political careers without cutting into pharmaceutical bottom lines (Courtwright 2010). Because of these factors, addiction has been incompletely medicalized and care takes place in a variety of venues, each with differing treatments and regulations (Wilton and Moreno 2012; Campbell 2012). While the partial medicalization of addiction did not completely shift its treatment from carceral spaces to medical

spaces, it complexified the relationship between the state and addicted bodies and diversified the ways through which the state exercises biopower.

Medicalized Approaches

When considered as technologies of care, addiction treatments fall on a spectrum from the fully medicalized (pharmaceutical interventions), to coercive, involving the use of state power to control behavior. The place of medicine on this spectrum is unstable due to the persistent use of the criminal justice system to treat the mentally ill and the substance dependent. Simultaneously, pharmaceutical companies work to offer treatments for addiction that can be given to address it as a disease of brain functioning (Meyers 2013). Thus, the problem of addiction can be treated medically with a pill, or behaviorally with jail time (Dackis and O'Brien 2005).

Biomedical interventions epitomize the construction of addiction as a brain-based illness. There are two main treatment regimens which address addiction as a brain-based disorder, Methadone Maintenance Therapy and Buprenorphine. While these treatments rely on similar ideological underpinnings through locating addiction in the brain, the social structures of their provision are very different. Methadone maintenance is represented as a pharmaceutical 'cure' for opiate addiction through blocking pathways in the brain which respond to the pleasure of the heroin high and the pain of withdrawal. The NIH pioneered Methadone maintenance, which represented one of the first efforts to biomedicalize addiction treatment. As one ethnographer put it: "The 'dope' became 'medication,' the 'addict' became a 'patient,' 'addiction' became 'treatment'" (Agar 1973 in Bourgeois 2000). In theory, the provision of methadone maintenance in closed settings allows individuals to address drug cravings without having to resort to crime or expose themselves to health risks. Doses are monitored with computer technology to ensure that

patients do not take more than their recommended dose and patients are breathalyzed to prevent the use of multiple substances (WHO 2012). As an alternative to imprisoning substance dependent individuals, it also provides another venue through which the state can exercise biopower. Rather than 'cure addiction', methadone treatment creates docile subjects whose source of pleasure has been criminalized by the state. Methadone represents "the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity" (Bourgeois 2000, 167). The medicalization of addiction is once again intruded upon by the conception of dependence as a behavioral defect, medical projects to create 'healthy' people become state projects to create 'normal' people.

The Drug Treatment Act of 2000 allowed for the wider provision of prescription opiates outside of methadone clinics and into traditional medical spaces. Shana Harris describes how Buprenorphine, the main drug licensed to be dispersed in these settings, was now able to be prescribed by physicians with proper training and licensing. The shift from the clinic to the office meant that treatment was expanded to population who might be discouraged to go to methadone clinics, such as whiter, younger, and more wealthy addicted individuals. The goal of these drugs in the setting of general medicine was to normalize the lives of users and provide them freedom not afforded in methadone clinics. While Buprenorphine offers patients and practitioners an opportunity to be included into "normal" spaces of biomedicine, it still relies on the underlying assumption that an addicted body is not a docile body and thus must be normalized (Harris 2015). The transition from Methadone to Buprenorphine represents expansion of clinician's ability to exert bodily control, but these treatments remain under the control of the regulatory mechanisms of the state. The state exerts biopower through bodily normalization as an alternative to prison, enabling normalization to entitle a person to a body beyond the limitations

of bare life, a term often used to describe prison life as a mere biological fact with any sense of quality removed (Agamben 1995).

Discussions involving the change in treatment patterns from methadone to buprenorphine and the difference between state responses to heroin and to prescription opioids necessitate an examination of the role of race in these events. Helena Hansen has been at the forefront of these investigations through her work examining the social backdrop of what some have termed the 'opioid epidemic'. Hansen's main contention is that the differences between the ways in which primarily white prescription addicts and primarily black and brown crack addicts are clinically treated is indicative of deeper racial inequities involving both medicine and policing. The demonization of pharmaceutical companies rather than addicts themselves demonstrates the ways in which the War on Drugs is a continued process of racialized violence. Hansen's work also reminds us that addiction therapies, biomedical or otherwise, are not as "colorblind" as dialogues portray them to be (Neutherland and Hansen 2016). This colorblindness is especially insidious considering the massive racial disparities resulting from drug convictions in the US (Pettit and Western 2004). While my work is situated and contextualized outside of US histories of oppression, it demonstrates the persistence of issues of race, class and gender which remain pertinent in all discussions involving drug treatment and criminality.

Addiction and Punishment

Before departing to conduct fieldwork in Nepal during the spring of 2018, I had worked in a rehabilitation clinic which primarily served individuals just being released from prison who had negotiated drug diversion as part of parole agreements in Hawaiʻi. Within the clinic, where I volunteered as a mentor, I was struck by the overwhelming sense of return: "It's her first time, but I have a feeling we will be seeing her again" was a common refrain. The assumption was that

through the funnel of the criminal justice system, an individual would return to state sanctioned treatment multiple times. Angela Garcia describes similar cycles of return amongst the Hispano population of Heroin addicted individuals as caught in a cycle which alternately deems them "patients" with a chronic illness within a treatment setting, and "prisoners" when they inevitably fail to govern their bodies to the standards of the neoliberal individualized state. In both manifestations of control, both the clinical and the carceral, near absolute biopower is exercised through controlling movement, what is eaten, and how patient/prisoners go about the banal acts of everyday life (Garcia 2010). While the clinic where I worked was a medical space, many of the patients were there as a part of parole agreements, meaning therapeutic failure would result in tighter restrictions or jail time. Although drug courts and clinics provide progressive alternatives to direct incarceration, they demonstrate the connection between projects of normalization and criminality. The biomedical and carceral space work interchangeably to create docile bodies in the US context.

In addressing the state, Garcia utilizes Michel Foucault's notion of pastoral power, in which the monolith of the state governs and creates passive bodies under the guise of benevolent action (Foucault 1982 in Garcia, 2010). In both my own and Garcia's clinical experience in the US, the state's ability to control, exercised as both Foucauldian biopower and biomedical hegemony was near absolute. The "states of exception," which allow human bodies to be interned in medical and juridical spaces, were the result of a homogeneous state, acting through both medical and corrective appendages (Agamben 2005). Prison represents a space of exception for addicted bodies as "the United States has a disproportionate number of prisoners, and most have been incarcerated for drug-related crimes, their addiction is seldom treated within the prison walls or, more importantly, after they are released to a drug-infested environment" (Dackis and

O'Brian 2005, 1432). The mark of addiction creates a state of exception which deprives sufferers of both personal freedom and their right to treatment.

A central idea in the creation of addiction as a state of exception is the perception of substance abusers as immoral. Addiction is framed alongside other criminal activities, making the concepts of drug use and criminality almost inseparable. Biopower and the ability to discipline one's body is an important part of the thinking which makes this possible. Foucault describes the disciplined body as the docile body, that which conforms to state goals. An undisciplined body faces the state's wrath and is punished into compliance (Foucault 1995). Many sociologists have discussed the tendency of the state to police the habits and pleasure-producing activities of the lower classes as harmful to the moral order (O'Malley and Velverde 2004). Since the substances used by the lower classes or the lowest 'lumpen' class, are harmful to the desired social order, the state forms a punitive relationship with users, and the control of the potentially damaging substance takes the form of enforced clinical surveillance or relegation to situations of precariousness, where drugs are consumed on the periphery (Garcia 2010; Bourgois and Schonberg 2009). Behavioral governance, when coupled with the punitive state, simultaneously creates subjects expected to self-govern, while rigorously policing the ways in which citizens form bodily subjectivity. The state thus intervenes as an enforcer, a harm-reducer, or a rehabilitator depending on the population with which it is interacting.

Gorgio Agamben expands this theoretical tool by stating that the sovereign state can define inclusion, those to whom the state grants full rights, by who it excludes: those who do not qualify as citizens and can therefore have their rights revoked. In this way, the state can claim to uphold human rights while denying freedoms to people it defines as behaviorally "ill" (Agamben 2005). The state's juridical approach is to separate those who use marked substances as "bare

life," which allows the revocation of basic rights through internment in the criminal justice system. When the state is strong enough to fully exert biopower and control life and death through inclusion and exclusion, this style of intensive governance is possible. In weaker and less homogenous states, biopower is still exerted over addicted bodies, but the sovereign who defines the state of exception is less definite.

Conceptions of Foucauldian biopower operating in western carceral and healthcare systems rely on a state which is both centralized and coordinated in its goals to create normalized bodies. In both biomedical and juridical manifestations, the creation of docile bodies has become the focus, as incomplete medicalization has structured the response to substance abuse. This response involves the continued use of the criminal justice system as the primary interaction between the state and addicted individuals. The conceptualization of addiction as a behavioral defect and a crime was internationalized through War on Drugs politics which pressured the Nepali monarchy to illegalize drug use through threats to suspend aid. Thus, while state biopower is not exercised in a centralized, Foucauldian way in Nepal, the relationship between addiction and punishment remains despite responses to addiction being formed within the crucible of a health crisis. Different departments of the Nepali government hold different conceptions about the ways in which drug addiction should be categorized and addressed. The medical sector thus has limited interaction with the juridical, meaning privatized care bridges the gap between the two. The way the state is present in the provision of care to addicted individuals is inconsistent and creates unregulated spaces of violence through its presence and its invisibility, essentially meaning biopower is exercised through private centers in a neoliberal marketplace of care provision.

Chapter 3. Private centers, Spaces of exception

A 500 Rupee taxi ride brought Dr. Acharya and myself from Ratna Park in central Kathmandu to the outskirts of the city, where the houses become newer and larger, the air less dusty, and the roads begin to tilt up toward the foothills of the Himalaya. After exiting our taxi amongst the tea stalls and kaja restaurants on the main road, we began to look for Drug Care Nepal, the city's most popular (and likely most expensive) drug rehabilitation facility. After checking in with the guard at the gate we were told "*tapāīharuko phone ra camera yahā rāknuhos*," leave your phones and cameras here. However, after a warm and seemingly overly welcoming greeting from the assistant manager, we could retrieve our devices and to film and record whatever we liked. We heard call and response exercises mingling with that of the birds and the summer wind brushing through the trees and prayer flags of the adjacent houses. The repetitious exercise sounds were emitted from a large three-story building painted in bright hues. While the door to this building was locked with two metal gates, the wooden door to the owner's office was open to the crisp monsoon air. One pair of women's pumps and Italian leather shoes greeted us as I slipped off my Vans and Dr. Acharya unstrapped his sandals. We walked in to be greeted by the clinic owner, Mr. Shamsher, sporting an immaculately trimmed mustache, sitting in his office covered in certificates of merit and photos of him and his wife shaking hands with international celebrities. Mr. Shamsher said he could meet with us briefly and arrange a tour, but then he must be off to prepare a talk for International Drug Awareness Day.

After Mr. Shamsher had left to attend to his urgent business, Prashant began to take us on a tour of the premises. We walked from locked gate to locked gate, and into the detox room, where a solitary man lay curled in a small bunk, clearly in agony as Prashant described why the center administered vitamins rather than pain medication to individuals who were suffering

through the process of detox. Prashant, a former real estate agent turned drug treatment officer stated, “These vitamins are the deficient vitamins. These revitalize the body in a short time.” He continued, explaining that this phase of treatment was meant to bring drug user’s mentality into the space of the center, “If I am a drug user I am not here, I don’t know what is going on. So, the objective is to bring us into the present. So they can focus on the present.” As I toured the rest of the center with Prashant and Dr. Acharya the “present” seemed to darken. The solitary man detoxing alone rolled over, clutching his stomach, observed by two red-vested attendants guarding the door and a young man no older than 20 in a doctor’s lab coat.

The attendants guarding the man in detox and conducting many of the drills were “graduates,” distinguished from yellow-vested “students” who had yet to finish the course. Students are marked by the yellow vests they wear, while graduates wear red. After students finish they become graduates. In Prashant’s words, “They finish the course, then they work one or two months in a different department.” From what I saw, graduates were doing most of the instruction and guard work in the clinic. Prashant said this was because “Once a person finishes the 6-month program, they are a graduate, meaning they have learned everything in the course, but that does not mean that they are ready to go home.” DCN posits that small amounts of responsibility help a young person stay sober during their transition to the outside world. In practice, using graduates as caregivers was one of many aspects that was permitted within the center as a space of exception. This style of clinical organization is made possible through the physical and theoretical location of DCN. Even before I was told more about mistreatment inside the center by ex-students, Prashant’s tour gave me the overwhelming feeling that DCN was a space apart. The center was a closed loop, from the initiation of students to the departure of graduates, DCN had peripheralized itself beyond the limited reach of the state. DCN was located

on the margins of the city, treated those marginalized by their substance abuse, and operated on the margins of medicine.

The ability to operate on the outside of systems of regulation is no accident, but a system of arrangements which maintains and exploits a status quo. Administrative bodies, such as the Ministry of Home Affairs and the Ministry of Health, have created protocols for the proper operation of rehabilitative services to those living with substance dependency issues. However, these regulations are loosely enforced through MOHA and police mechanisms, where only extreme cases of neglect are dealt with. In this system of affairs, police act as an appendage of supply reduction, focusing their efforts on traffickers and dealers to reduce the supply of drugs reaching urban centers. In their own narration, police have nothing to do with treatment methodologies which occur inside of centers. Former private center clients offer an alternative narration, in which police are active collaborators with certain centers, receiving commissions and providing space in prisons where potential clients can be recruited.

In this context, spaces of exception are created through state multiplicity, a term I use to describe the various ways in which state presence and invisibility is represented. Peripheral spaces like DCN are created in part by forces of medical privatization and the neoliberalization of the Nepali economy described above. Private centers operate within the laws of the state, while simultaneously breaking these laws through patient mistreatment. Multiplicitous governance in Kathmandu creates a state which writes protocols for ethical treatment of the substance dependent with no mechanism to regulate for compliance, all while state biopower is used to ensure certain private centers remain full of clients. This chapter will examine the MOHA protocol and surveillance mechanism before theorizing private centers as non-traditional 'spaces of exception'. It will then discuss the ways police exert state biopower in the provision of

clients to private centers and the fluidity with which laws and rules operate in peripheral spaces of governance and non-governance.

Like Gupta's description of poverty reduction efforts in India, a central argument in this discussion is drug rehabilitation complicates definitions of sovereignty with regards to conceptions of a unitary state (Gupta 2012). While the state appears to have a cohesive agenda operating through the bureaucratic apparatus of the Ministry of Home Affairs, ethnographic scrutiny reveals a state which exercises biopower in the form of punishment through both state and private entities. While the state works toward goals of the production of docile and sober bodies, it does so in conjunction with private rehabilitation centers, writing them into legislation involving substance abuse. In allowing private centers to operate as spaces of exception where violence against subjects marked as addicted occurs, the state forgoes its exclusive rights to exercise legitimate violence and becomes a stakeholder in the new marketplace for care.

Protocols and Governance

Protocols and their enforcement are key elements in the algebra of the creation of private clinics as spaces of exception and the disbursement of state sovereignty. To understand how violence can be permitted to be given as treatment, the ways in which protocols act to create images of care versus the actual care that is provided is crucial. Below I will discuss the 2003 guidelines for private clinic administration drafted by MOHA and the various barriers to the actual practical use of this document. I argue that while this document is severely limited in its application because of the lack of monitoring mechanism to ensure compliance, the protocol still maintains a specific status quo. The mixture of state politics and private industry is a strange world where mountains of profit are disguised by veneers of benevolence. Arundhati Roy describes this space as "a sub-world, whose life's endeavor was to mask intent...They breed and

prosper in the space that lies between what they say and what they sell" (Roy 2002, x.v). In Nepal, this is a space of government multiplicity in which mechanisms of profit creation are masked by protocols and stated policy.

Private centers make up much of the rehabilitative care given in the Kathmandu Valley. Drug Care Nepal is one of many private treatment centers that are run as non-governmental organizations which operate under limited governmental oversight. There are other, less widely used sources of care, such as free government care provided at OST and de-addiction centers run in partnership with INGOs. While an OST center generally provides services to around 200 patients every day, there are over 100 for profit treatment centers in the Kathmandu Valley alone. These centers vary widely in their programming, their cost, and the quality of their treatment. Some are hugely profitable businesses, catering to the upper middle class exclusively. Dr. Sagun and I usually talked at his office at a teaching hospital where quality care is provided, but which is constantly plagued by resource shortages. In this setting he once lamented about one center charging exorbitant fees for care: "And just imagine the amount of money they are making, especially from a poor country; its huge. For three months you have to pay 15,000 dollars. That is expensive even in a developed country." The profitability of running a rehabilitation center is a factor that must be understood when explaining why the current status quo is worth protecting. While there is a diversity of options in both cost and treatment style, the ability of private centers in Nepal to operate with limited oversight, prioritizing profit over patient wellbeing, is widespread and represents care for a medical condition whose definition, treatment, and practice are being determined within the fraught arena of the neoliberal economy. The government is not absent in centers like Drug Care Nepal, but its presence is inconsistent.

Government multiplicity is best shown through the apparatus charged with drug supply and demand control, the Ministry of Home Affairs (MOHA). Past evaluations of Nepal's response to drug addiction have viewed the apparent centrality of MOHA as an advantage over other decentralized forms of South Asian governance because supply and demand control are based under the same ministry. In theory, centralization avoids ideological clashes between, for example, police and medical professionals (Ambekar et al. 2013). However, the diversity of MOHA's responsibilities, ranging from the provision of passports to monitoring the police and army, means it does not operate as a centralized bureaucracy and is often overwhelmed and ineffective. In one of our conversations, Dr. Sagun described MOHA as an organization that "has bigger priorities compared to substance use disorder." As someone involved in securing funding and promoting exchange between governmental departments, he explained that:

> As far as the regulating body, it is still a part of MOHA, while the harm reduction program is a part of the Ministry of Health, so there are two different authorities and there a constant toss between them as far as projects. So we are trying to bring them together for a technical working group, but then, easier said than done in Nepal. It's throw and catch.

When Dr. Sagun discussed throw and catch, he was referring to the many shifting avenues of supply and demand control exercised by the Nepali government. The place of the ministries involved in the creation of drug policy is unstable. Sinhas (2008) describes the uncertain situation in which "the current drug control strategy building exercise faces an uncertain future with the upcoming change in government and eventual change in personnel" (Sinhas 2008, 24). Government biopower, as exercised through the control of drug supply and demand is spread throughout a government in a state of flux. In this climate, the state can create grand declarations like the 2003 code discussed below, but is unable to monitor for compliance due to shifting responsibilities and saturated departments. The constant flux in strategies, funding

mechanisms, and personnel means that MOHA is in an almost constant state of change. This perpetual internal disorder allows the rehabilitation industry status quo to be maintained.

Using a set of guidelines developed in 2003, MOHA administers licenses and monitors clinics. These guidelines present a progressive approach to drug intervention, emphasizing patient rights and including initiatives sponsored by the Ministry of Health. In their description of the location and amenities that a center must provide, the guidelines state that each should have facilities which promote a healthy, peaceful, atmosphere through having sunlight and being away from polluted areas, and should have facilities for personal advancement, such as libraries and computer labs. In regards to staffing, a center is required to have individuals trained by the Tribhuvan University Psychiatric Department, the leading university in Nepal for psychiatric training. A psychiatrist with approval from either MOHA or TU is also required to be on staff, an issue that will be discussed in later chapters. These guidelines also state that family involvement in the treatment process is crucial, and that patients should be able to reach family members easily. Finally, the guidelines describe the mechanism of state surveillance responsible for ensuring compliance with these regulations. They state that each center will be examined once every six months and that from this examination, a report will be produced detailing the center's practices. This report is to be submitted to a council with members of the Ministry of Health, senior clinic owners, and the MOHA council on drug control. If mistreatment occurs in facilities, the doctors and other medical staff who are present are responsible for reporting it. The center will be held accountable for abuse and those which fail to follow guidelines will be shut down.

Apart from the regulatory council described in the protocol, centers are largely insular in their efforts to regulate practices. The 2003 protocol relies on the medical responsibility of doctors or other medical professionals to report mistreatment in clinical settings. From my

experience at DCN, this reporting system misses major sources of potential abuse. At DCN, all training in both treatment methodologies and administration was internal, with no medical or government oversight. DCN was part of a network of care centers, where individuals from other affiliate centers could come for 'training'. This allowed the center to create its own titles of medical hierarchy, as shown below. Prashant described this system of training and accreditation:

> Prashant: For instance if somebody wants to take a training course in South Asia, any staff training, we are the ones to provide that training. We got approval from the main office for this to be a training center.
> Robin: So you can become a doctor of (DCN), a masters…?
> Prashant: Yes, the courses that all administrators have done are listed below the names.

While not subject to the same regulatory mechanisms as biomedical spaces, private centers are able to co-opt the terminology of biomedicine to create images of medical legitimacy. One wonders, was the doctor monitoring patients in the detox center a doctor of DCN or trained at a teaching hospital? Just as the MOHA protocol implies that all private centers uphold the values of patient dignity and human rights, practices such as DCN's manipulation of medical terminology allows them to bypass major regulatory mechanisms in place to ensure patient safety. Loopholes which are easily exploited due to government multiplicity and flux maintain this status quo, in which patient mistreatment becomes normalized.

Spaces of Exception

The constantly shifting nature of governance and regulation described above creates spaces of care whose existence are acknowledged but not controlled. Within these spaces, human rights usually defended by both moral and legal codes, can be infringed upon through the creation of immoral subjects, invisible to the eyes of the state. State invisibility in the context of private treatment is thus a major factor in making human invisibility possible. The elements facilitating state absence and presence in response to opiate addiction are best theorized through

Giorgio Agamben's 'states of exception', especially as explained by Akhil Gupta's conception of 'Red Tape' in the exploitation of the Indian poor. For Agamben, states of exception, translated in this context to spaces of exception, are representative of the full extent of state biopower, where claims to physical wellbeing are suspended through the categorization and exclusion of a defined lawless minority. This is made possible through the denaturalization of citizens, where inclusion in society is defined by who it excludes; people who kill, who steal, who use drugs. These individuals are transformed from citizens to "bare life," where life is acknowledged as a mere biological fact, outside of the humanness afforded to citizens (Agamben 2005). This conceptualization has been used to describe spaces like Guantanamo Bay, where torture is simultaneously condemned and illegal, but nevertheless justifiable due to the exclusion of a 'terrorist' minority from the benefits of citizenship as threats to the common good (Mertus and Rawls 2008). Invisibility and the ability to control human life is made possible through the biopower of the monolithic, sovereign, Foucauldian state.

The Foucauldian conception of the state used by Agamben as the structure able to define bare life is predicated on western systems of governance where state appendages work towards largely homogenous agendas. Akhil Gupta challenges scholars who have used this notion of the state as a monolith, explaining that in the Indian, and many other South Asian contexts, "a situation characterized by fragmented, dispersed, or overlapping sovereignties, and a state that is pluralized, multileveled, and decentralized, it becomes more difficult to mobilize the theoretical dualisms that characterize Agamben's relationship between the state of exception and bare life" (Gupta 2012, 17-18). Agamben's construction of the sovereign who is privileged to create the population who is reduced to bare life becomes complicated in situations of complex governance, where the state is not unitary and does not have a cohesive agenda, but is rather an

amalgamation of many agendas. Thinking of the state in this sense, "intention is a poor place to start" as it is not a unified force (Gupta 2012, 46). The situations of governance Gupta describes do not create spaces of exception through absolute power; rather, they create zones of governmental indifference through the decentralization and inconsistency of the ways in which power is organized and exercised. He also reminds us that the violence done by this style of governance is not due to a lack of organization, it is the result of "the deliberate actions of social agents. One must keep in mind that certain classes of people have a stake in perpetuating a social order in which such extreme suffering is not only tolerated, but also taken as normal" (Gupta 2012, 21). Rather than take the structure and will of the state as naturalized, Gupta urges that it be taken up as a unit of analysis. With the concept of analyzing power in mind, I will now explain the ways in which the two mechanism of government enforcement, MOHA and law enforcement, endorse the existence of private centers but fail to monitor them.

Regulations in Practice

While discussing the MOHA protocol with Mr. Shamsher, he stated,

> They (MOHA) have a lot of criteria. They have boundaries like you can't take too much money from people. If we followed that list we would not be able to afford to run. If we say we can only take Rs25,000 per month for a fee we won't even be able to feed them properly. So we can't always meet their demands, lots of rehab centers they have their own (rules and regulations).

Later in our discussion, he continued "right now all centers are run as NGOs, but we are trying to become like a company." These statements and narratives of center creation demonstrate the ability of private centers to sidestep governmental regulation, and embrace the ethics of entrepreneurship and business that accompany the creation of care as a neoliberal market commodity. The ability of centers to form "their own rules and regulations" is directly related to the lack of regulative capacity of MOHA and its inability to control the activity occurring within

centers. Opening a private center under these conditions followed a similarly consistent narrative of loose regulation as well. From these depictions, there was a sense that anyone could open a center and turn it into a profitable business: "You can just take a four-room flat and create a rehabilitation center and then start. Nobody is going to come see what is going on, there are so many" stated one representative of a narcotics users advocacy group. In one discussion with Dr. Sagun he stated that "they open an NGO, the clients come in, and they are there for three months to a year. They say there's a lot of training that goes on in there, but it is not well structured and it's based on the idea that there is a universal way of handling drug use. There is a protocol, it is just not abided by." These narratives paint a picture of rehabilitative care as a neoliberal marketplace, where ideals of entrepreneurship rather than state or medical regulations govern proper treatment.

In the Nepali context, governmental structures have become neoliberalized, especially those involved in the provision of healthcare. Drug rehabilitation demand control is centered around collaboration with "NGOs," which are largely run as loosely regulated businesses. While these centers are recognized as a part of the government response to addiction, they do not necessarily share the same agenda as MOHA or the Ministry of Health. As spaces that are essentially businesses, continued profit through a consistent flow of patients is the primary motive. This is Gupta's government multiplicity placed on the neoliberal marketplace, where that marketplace is written into law and is tangled within structures of governance. In this way, governance and business become intertwined, turning patients into profit. The MOHA protocol thus provides a veneer behind which a minority of private center owners and involved government officials and police amass wealth through the exploitation of addicted patients and their families.

Police Exception

Another thread in the veneer of systemic exploitation of Nepali substance abusers is the police. While in official documents and in press statements police are specifically on the supply control side of MOHA's equation to reduce drug abuse, verbal testimonies of former private center patients paint an alternative picture. The interrelation between police and private centers is not always hidden. A 2012 headline in the popular newspaper My Republica reads: "Anti-drug campaign launched in Nepal" and describes a vague collaboration between the police and DCN. While other efforts between care providing organizations and the police have been seen as a step in the right direction by Nepali user advocacy groups, this collaboration is between a business and an appendage of state biopower and represents a continuation of a trend in which state biopower is utilized to recruit patients to private centers in the interest of creating wealth for both centers and certain police officials.

As an appendage of the state which can punish, the actions of the Nepal police regarding drug users fit into constructions of sovereign power (Agamben 1998). However, as Gupta notes, "An ethnographic focus...makes evident that the materiality and solidity of the state dissolve under scrutiny" (Gupta 2012, 45). In the case of policing in the modern state, while Agamben's conception of the state would imply that police have a "formal monopoly on legitimate violence," ethnographic analysis reveals a more complex situation, involving police and private entities operating in tandem to exert biopower in the form of clinic-situated violence (Hansen and Stepputat 2009, 193). The collaboration between law enforcement and private entities with the goal of creating docile citizens changes the ways in which state action is conceptualized, as state projects of normalcy creation and private projects of profit creation become intertwined. As will be shown below, clinical referrals form the basis of an economy of care, where time

incarcerated can be exchanged for time in rehabilitation. The ability of police forces to deny that they take part in this economy of for-profit biopower is again related to the multiplicitous state. Gupta explains: "This depiction of the state is a highly complex array of institutions with multiple functional specializations...Attributing organizational unity...to such a welter of institutions might defy common sense" (Gupta 2012, 46). Thus, it is possible for district level police to preach progressive agendas, while on the interpersonal level police participate in economies which overlay treatment and violence.

With this conception of state sovereignty in mind, it is not surprising that not all police are aware of this process. It was hard to ignore the number of individuals who told me they were brought to clinics by police representatives or recruited to centers while in jail. Dr. Acharya convinced me that we needed to get a fuller picture of the process and that he could fix a meeting with a government official representing the police. After waiting outside the police station where we thought we would be meeting the spokesperson, Dr. Acharya received a call and the two of us piled back onto the motorcycle to visit another administrative office, just a short and bumpy ride away in after work Kathmandu traffic. We arrived and walked up to the fourth floor of a tall building in the mostly residential neighborhood. Dr. Acharya had assured me that this spokesperson would provide much needed information about the ways in which drug users and dealers were apprehended. However, our conversation revolved around the topic of private centers, rather than police strategy. Specifically, this official described the ways in which private centers were essential in the state response to addiction. "We have more concern about supply control, but there is another component, that is demand reduction. So rehabilitation centers are more related with this demand reduction side." When discussing what happened in centers enacting demand reduction, the police stance is that activities occurring inside centers are not

their concern: “Police do not recommend clinics generally because they are different fields. Police are neutral in this selection.” This initially struck me as an effort to ensure that police did not interfere in private enterprise. However, on further reflection it became clear that this statement was a demarcation of responsibilities. The police represented supply reduction, meaning that demand reduction, the activities which take place inside private centers, was outside of their purview. Police “investigate some homicides in centers” and “some substandard centers are certainly partaking in substandard activities;” however, “MOHA, they are developing these policies, they are responsible for monitoring these facilities and activities.” The Nepali state thus sanctions the existence of private rehabilitation as part of demand reduction, but does not possess the ability to regulate the activities that occur inside, as those resources are concentrated on supply control. Full depictions of the activities of police are thus disguised through exercising biopower through state and private entities.

Another factor that made me question the police’s characterization of their role after my meeting with the spokesperson was the conflicting reports of how people arrived at centers. As I conducted interviews with ex-users and private center alumni at the OST center, many patients contradicted what the police spokesperson had said and stated they arrived in private clinics either through direct police involvement, or through referrals which could be conducted in Kathmandu Central Jail. I typically asked these men how they learned about treatment and the process by which they were brought to private centers. Arbin, who had just married after becoming sober, described his experience of being placed by his family at Drug Care Nepal, stating that: “They restrained me, they have a consent with the police. They call the police; the police came to the house and they arrested me and took me to DRC. This happens to other people too, this is the process there.” In another interview, Sunil, a young man who worked in

construction but was aspiring to own his own shop and whose incredible life will be described in further detail below, described another clinic as having an even more intimate relationship with law enforcement: "If police catch with like a little bit of marijuana, police will send to rehab because the rehab will give a commission to the police." These comments paint a picture in which state biopower is used in tandem with private enterprise. In this system, the creation of docile bodies is simultaneously the exploitation of profitable bodies, bodies marked by substance dependence and in need of change

In addition to attending multiple rehabilitation programs, Sunil's young life had been marked by numerous encounters with police, a few of which had involved incarceration. Before his first experience in a rehabilitation center, Sunil had been taking brown sugar heroin orally, but while inside, other clients in the center "saw my arm and they said, 'Wow big veins! If you injected...' Blah blah, so I learned there how to inject." Sunil began injecting drugs with another friend who had been through the same rehabilitation program, which lead to another encounter with the police. His friend's wife did not like Sunil's influence on her husband and "because he and I always use drugs together, she called the police!" Sunil didn't know his friend's wife had called the police on him, so he rode his motorcycle home. "I didn't know the police were following me I am just speeding, I don't know, seven days I was a fugitive." Finally, the police caught up with Sunil while he had a large amount of heroin on his person, but "one hand was free, and I slooowly took my purse and threw it into the other house's rubbish pile. Then I told my friend with my eyes that it was there. There was 12,000 in my purse and the 8 grams. The police took me to prison and my friends went to a resort and enjoyed, using drugs and being in the sun."

After Sunil's brief stint as a fugitive and his avoidance of serious criminal charges through discharging the large quantity of heroin in his pocket, he was taken to jail and his family was contacted: "The police caught me at 11 and my father got me out by 3 o'clock. Then there was a boy from the rehabilitation center there, and he told my parents to put me in the rehab." Sunil's parents agreed to take him to the center rather than have him spend more time in jail, but Sunil had no desire to be in the center. "I said if you put me here and you go, I will do suicide. After a while, my father, my uncle, and one local don boy, they came and consulted with the rehab counselor and they took me home." Sunil's tale is indicative of his cleverness, quickness, as well as his sense of humor, to which I cannot do justice in my retelling through text. It also provides an insight into how treatment centers use jails as recruitment opportunities. Sunil was able to reduce his jail time through enrollment at a private center. His completion of the program was not the object of this deal, rather it was the money exchanging hands before Sunil used one of the few negotiating tools left to those in private centers, his own life, to leverage his way out.

Through Sunil and Arbin's descriptions, the police become involved in providing patients to private rehabilitation centers through collecting them from their families, delivering them directly to centers, or facilitating an atmosphere where patient's families can be marketed to. Through the statements of ex-users, the state, as represented by police, provides avenues for individuals to be interned in private centers, with the knowledge that some centers are providing care that is violent or "substandard." These accounts are not meant to contradict the statements of the police representative, but rather to show that the ways in which the state exercises power through policing have many local manifestations within the everydayness of structures of biopower. The state's regulation of bodies and lack of NGO regulation makes the state complicit in private center violence, both through the provision of clients to private centers through the

ways shown above, and through mandating the existence of private centers but refusing to regulate them. Centers are made into spaces of exception through a state which is represented in both its form and its absence, possessing the ability to create codes but not enforce them, to preach human rights and proper care while perpetuating cycles which ensure negligence is possible. As stated by Gupta, while the violence perpetuated inside of clinics is interpersonal, the everydayness of violent acts within the context of treatment is the result of structural violence, the active yet banal process of denying a certain segment of the population claims to physical wellbeing (Gupta 2012).

Stories of police involvement in clinical referral remind us that “we see the state here not as a regulatory institutional configuration standing over and above the population it governs but as being made and remade at the margins” (Das and Randeria 2015, 12). The intent of bureaucratic agendas, formed at high levels of government, break down within peripheral institutions like private drug rehabilitation centers. These mechanisms which make the production of human misery legal represent state sovereignty as a diffuse practice, one which is poorly conceptualized by a unitary state. When overlaid with the economic opportunities of private enterprise, Gupta’s diffuse state creates the exercise of biopower as a market commodity, in this case due to ceding health sovereignty to private centers. Abramowitz and Panter-Brick (2015) ask “Do NGOs-in coordination with each other, with donors… act like a state? Are they capable of carrying a state’s health sovereignty…?” (Abramowitz and Panter-Brick 2015, 140). In the Nepali context, the short answer to such a question would be yes, NGOs take on state roles of alleviating a public health concern through treating addicted individuals. But when one considers the incomplete medicalization and continued moralization of drug use as well as the space of private centers on the periphery of medicine and its associated regulation, this answer

becomes more nuanced. In the Nepali case, the state has remained involved on the margins, playing a role both in exercising biopower and collecting profits while narrating regulative capacities which do not exist.

Our tour of DCN had finally come to an end, the two hours filled with explanations of treatment methods while walking in and out of rooms full of interned men had exhausted me. Many of these men's faces remained with me as I separated from Dr. Acharya and rode the bus home. Before we left, Prashant pointed to the fence and said: "Once they are in, there they are in, we do have a security system. They cannot leave until the program finished," as we knocked on the gate, waiting for one of the red vested graduates to undo the double lock. The MOHA protocol defines security as something which would keep patients inside of clinics, and as conditions in which patients feel secure within the boundaries of clinical space. While the barbed wire, locks, and guard houses and DCN generally ensured this would be the case (though escapes do occur), these mechanisms also tie these individuals to a treatment mechanism operating within the fraught arena of care in urban Nepal. While the government produces reports, police arrest, and private clinics advertise, living bodies are inside this place, imbibing the instability of it all.

Presence and absence of the state mirrors the appearance and disappearance of the substance dependent in different spaces in Kathmandu. Police-escorted appearances in private clinics imply a disappearance from the extended family homes from which many of these young men live. Some of these disappearances are permanent, as young men die from suicide resulting from a bride's unwillingness to marry a drug addict, or from HIV contracted through the everydayness of injecting drugs. The following section will examine how these appearances and disappearances are made possible through the structuring of the modern Nepali family and the

private center creation of both addiction and the addict through various forms of media. In drawing attention to these factors, I emphasize the ways in which personal will and eventually human life is made disposable through the neoliberalization of disease treatment and its messy relationship with modern social structures.

Chapter 4. Narrating Addiction

As 70 pairs of eyes met mine, I awkwardly shifted my backpack from my right to my left shoulder. When Mr. Shamsher beckoned me to the front of the room, I realized I had been tricked, but it was too late to do much about it. I shuffled my way to the front where Mr. Shamsher and I sat at the far side of a conference table in front of every patient and staff member that worked at DCN. Ten minutes before, Mr. Shamsher had asked me if I had wanted to attend a 'staff meeting' since our interview that morning had to be cut short. I had agreed, hoping it would illuminate some of the inner workings of DCN. Instead I had become a piece of propaganda, as Mr. Shamsher described to the assembly that I was a researcher coming from the US to learn about the techniques of rehabilitation used in his center. After introducing me, Mr. Shamsher delivered an impassioned two-hour speech discussing his conceptions of the reasons for drug use and why drug users were morally defective. Mr. Shamsher explained to the audiences that:

> "Everyday people die but nobody comes themselves for treatment. If they have eye problem they go to the eye doctor, but why don't people with drugs and behavioral problems come here? Because they are abnormal. These people have no capacity to judge and just make wrong decisions, one after another"

He then pointed to a young client sitting in the front row and after telling him to stand asked him:

> Mr. Shamsher (To patient): The god has given you 100 years yes, but if you kill yourself, which you can do, can you not take that 100 years?
> Patient: Yes
> Mr. Shamsher (to the audience): Even though the god has given him 100 years, he can kill himself before that...Criminals and mafia, they do not kill themselves, they stay in nice lovely houses. They are not ruining themselves, they are ruining others. Drug users are the only ones who ruin themselves.

As discussed in the previous chapter, private clinics function as a part of the state's health sovereignty, exercising biopower within spaces of exception. Centers assume a sovereign role in exerting the will of the state in the therapeutic domain of addressing substance abuse. To

examine this process, we must determine precisely how private centers gain the authority to treat. What exactly do they believe they are treating and how is this conception created in the popular imagination? A tool that is useful in theorizing the answers to such a question is Samsky (2012)'s concept of scientific sovereignty. The author notes that a "regime of scientific sovereignty comes into being, displaces public power, and places itself in charge of fostering the lives of citizens of sovereign states. This control is diffuse, difficult to chart, and supposedly limited to problems soluble only by biomedical-scientific approaches (Samsky 2012, 328). As I will show below, the role of biomedicine in the creation of this type of sovereignty is more symbolic than material, as the authority, rather than the techniques of biomedical treatment, are employed to narrate addiction in a specific linear trajectory.

A central project at DCN and other clinics is the creation of addiction in the imagination of the public. The ability to create an illness is a power usually reserved for medical settings, where institutionally backed observations lead to the codification of signs and symptoms into nameable illnesses (Foucault 1994). However, the private clinic is situated as a space of exception on the periphery of medicine. This unique position allows private centers to co-opt tools and languages of medicine, giving their claims the air of institutional credibility. Using these claims, private centers perpetuate a version of addiction as a behavioral illness caused by individual immorality. This construction likens addiction to other forms of immorality which can potentially be dangerous to associated individuals, as immoral acts have the potential to affect a related person's moral standing. In equating drug use with dangerous immorality, private center addiction narratives justify the revocation of addicted person's sanitary and biological citizenship as a means of behavioral treatment. In losing the ability to make claims of personal wellbeing to

the state through being defined as ill in a way that is morally defiling, addicted persons become objects of the treatment center's knowledge, allowing violence to be given as treatment.

While they may use some of the language of medicine, private centers clearly delineate their treatment from OST clinical treatment which offers detoxification services based on the principles of evidence-based medicine, a term used to describe psychiatric best practices based on medical understandings of the body and individual patient history. Private centers define the treatment they provide as both behavioral and specialized to separate it from other forms of more inexpensive care offered at government OST centers. To make this distinction, private centers attack the methods with which psychiatry treats addiction, in particular the detox aids which come in pill form. Private centers create an addiction that is behavioral, non-psychiatric, and whose root cause is individual immorality. The definition of addiction presented by centers creates sufferers of addiction as dangerously immoral, meaning that addiction is a behavioral condition that must be treated outside of the home.

Their narration of addiction and treatment is codified by what I have termed 'vocabularies of certainty'. I choose this term carefully as to avoid stating that private centers use statistical reasoning to justify their claims. The numbers DCN and other clinics use to state their rates of individuals 'cured' of addiction are not figures that have been reasoned through exhaustive research, rather they are numbers meant to naturalize their form of treatment as the method that is most successful. Instead of adopting the techniques of medical statistics, they co-opt vocabulary to further claims to legitimacy. As I will discuss below, statistics work to naturalize claims to effectiveness as well as tell specific, seemingly irrefutable, stories.

Creating Addiction

Addiction is relatively new as both a moral category and an illness in urban Nepal, and those suffering from substance dependence disorder are primarily young adults. As a result, private centers can perpetuate a specifically Nepali definition of addiction which incorporates elements of familial moral obligations, dubious statistics, and specific relationships to the periphery of biomedicine. This definition is not ubiquitous for all private centers, rather, competing definitions of addiction and care are circulated through various media sources, where they vie for public affirmation. Simultaneously, Nepal's burgeoning psychological sector attempts to counter these narratives through asserting concepts of evidence-basedness and brain centric understandings of addiction. The instability of the medicalization of illness, as explained in chapter one creates a fraught arena in which competing understandings of bodily disorder partially determine lives, establish political willpower, and amass fortunes. A final noteworthy element of the Nepal situation is that the consumers in this private marketplace of care are parents of addicted individuals, not the individuals themselves. The ways in which private centers depict their treatment directly appeals to understandings of the identity of a proper son or daughter.

Mary-Jo Delvecchio Good has described the popular faith in medical procedures and technologies as “the biotechnical embrace,” seen through the ways individuals “invest in the medical imaginary – the many-possibility enterprise – culturally and emotionally, as well as financially” (Good 2001). Good remarks that this embrace is two-fold, medical practitioners and patients alike participate in the reification of curative technologies through symbolic and material investments. In this case, private centers profit off the conception that they provide a curative service, the kind that will restore one’s offspring to their proper roles through saving them from

addiction. During the speech described above, Mr. Shamsher explained the ways in which DCN typically interacts with parents about drug abuse, stating: "What is the major problems for drug use? Economic loss is a major problem, prestige is the major problem, family harmony breaking is the major problem. The family says we can accept, but we want to see them alive. So the people who call us have a big hope that DCN will give them a new son, who will not do these things." DCN plays on specific Nepali understandings of citizenship to develop treatment that will appeal to the medical imagination of Nepali parents. Previous chapters have examined how private clinics assume a limited form of sovereignty through the ways in which they are privileged to act in the place of the medical structures of the state. I will now examine the work that is done to create that authority as a commodity and a loosely medical treatment.

Within the private center creation of addict and addiction is the marginalization of substance abusers as non-citizens. In this case, citizenship implies an individual's ability to make claims upon the state. The rhetorical work of disenfranchisement lies on one side of what Scheper-Hughes and Bourgois have termed the "violence continuum" which "refers to the ease with which humans are capable of reducing the socially vulnerable into expendable nonpersons and assuming the license - even the duty - to kill, maim, or soul-murder" (Scheper-Hughes and Bourgois 2004, 14). The marginalization of the substance dependent can also be seen as an element of structural violence, through the ways in which addicted bodies become profit-producing entities, lacking rights and protections in cycles of dehumanization.

Narrating the Addict: Youth, morality, and danger

A central element in the creation of private addiction treatment as an "economy of hope" is the narratives private centers create about addiction and treatment (Novas 2006, 289). While some field of medicine have regarded the concept of narrative as the antithesis of the scientific

establishment of which they are a part, narrative forms the ways both patients and healers make sense of illness and healing (Mattingly and Garro 2000). The anthropological study of narrative is a vast area of inquiry, drawing on many disciplines from linguistics to performance studies. In the realm of medicine, narrative has been understood as one of the ways "the innately human experience of symptoms and suffering" is interpreted by care providers and receivers (Kleinman 1998, 3). While most of the literature in this genre examines the structure of narrative and what narratives tell us about the experience of illness, I examine how the use of a single narrative creates a specific conception of disease and healing regarding addiction. In the words of Mattingly and Garro "Powerful stories can shape future actions in decisive ways" (Mattingly and Garro 2000, 18). The ability to narrate the bodily disorder of another is also revealing of power dynamics between healer and healed, as "entitlement to tell the story of another's illness...can serve as a marker of other types of social relationships" (Mattingly and Garro 2000, 18). Below I examine the ways in which private centers narrate addiction, and how that narration marginalizes substance abusers in a way which removes them from their homes and places their treatment in the specific context of private treatment, rather than biomedical establishments. I draw on what I was told during my tour of DCN as well as Mr. Shamsher's speech to examine how narrative create addiction in the minds of parents and justifies practices which reduce the substance dependent to 'bare life' (Agamben 2005).

The concept of youth and its tenuous connection to morality and social change is crucial element in the narration of a "new" illness. The emergence of youth culture in Kathmandu developed simultaneously with the intensification of hard drug use and other activities deemed 'immoral' by conservative Hindu society. In Mark Liechty's examination of youth culture in Kathmandu, he noted that youth, specifically the terms " 'Teen' and 'teenager' almost always

described young, unmarried men who were considered unruly and delinquent…"teenagers" are disobedient, likely to take drugs, and usually male" (Liechty 2003, 229). In this description, youth is not a marker of a numeric age or stage in life, it is tied to a certain moral status, one which is at once foreign and dangerous. Young Nepalis coming of age during the era of globalization face the dual pressures of living up to international standards of success and maintaining local notions of moral purity (Liechty 2003).

The young men with whom I worked were coming of age and beginning to use drugs in a social climate far removed from their parents' world. Based upon her discussions with young men, Brunson (2016) explains the situation which was described to her as "social vertigo…the embodied experience of negotiating a state of globality" (Brunson 2016, 10). She claims that the young, unmarried, mostly middle-class men she worked with were caught in between local and global standards of being; placed precariously between their existence within the durable patrilocal family structure and their parents' expectations for them to be a successful global citizen. Young men expressed that they faced the common challenges of high rates of unemployment, low wages, and rising prices despite political rhetoric describing an era of *nayā Nepāl* (new Nepal) (Brunson 2016).

Brunson is careful to point out that to be middle class in Nepal means to remain limited by financial constraints, due to the scarcity of employment, even for the very well educated. As a result, "young men of a comfortable economic background found themselves with excess free time, looking for some activity to serve as a 'timepass'" (Brunson 2016, 109). 'Timepass' returns us to the idea of social vertigo; that *nayā Nepāl* is experienced within a tension between local and global expectation, where new youth identity is created as a bricolage within a generation struggling to define itself as something new while remaining inside enduring social and familial

structures. Although young sons are meant to support patrilocal families, they often end up remaining reliant on them throughout their youth. Some have attributed the prevalence of addiction in the Kathmandu Valley to existing within this tension, as youth drug use typically occurs in peer groups. Young people are depicted as facing challenges their parents do not understand, who use drugs as a means of stabilizing their identity and confidence building (Jha and Plummer 2014; Liechty 2003).

Factors such as stress, belonging, and self-care are absent from private center narratives about drug abuse. Instead, youth drug abuse and other immoral social acts are categorized into the definition of addiction as a behavioral illness presented by DCN. On my tour, Prashant described the purpose of each of the four modules of DCN treatment. In his description, treatment followed a consistent linear narrative of a sobriety achieved through properly understanding conceptions of morality. He stated that: "Drug detox is not sufficient, life should be improved. To do this you need to disconnect with the antisocial persons and learn how to ID who are good and who are bad. Second you need to know the do and don'ts. But when people take drugs it is like this "born to be wild" they will not accept any rules." The definition of addiction presented in this model goes beyond behavioral and medical illness to attack drug users' conception of rightness. It assumes a narrative of substance abuse which incorporates an amalgam of immoral practices, making one ultimately unfit to be within the household and the national community. This narrative fits what others have observed about connections between criminality and its danger to communal moral identity. In these narratives, characters like the "figure of archfelon, albeit culturally transposed, seems to be doing similar work in many places, serving as the ground on which a metaphysics of order, of the nation as a moral community guaranteed by the state, may be entertained, argued for, even demanded" (Jean and John

Comaroff 2006, 808). Criminal and immoral actors, like substance users, do not only defile their own claims to moral citizenship, but also risk communal identities of moral correctness. Their very existence thus threatens social moral order and justifies their separation and detention.

The Nepali concept of *Ijjat* is central in discussing youth morality and its relation to familial and social danger. *Ijjat* represents the "concept of status with a moral valence" (McHugh 1998, 164), and maintains a complex relationship to Laj or shame, not as a dichotomy, but as a place marker because "The idea of honor reflects a larger configuration: through this concept one's place in a given social world is defined and one's character as a moral person is assessed" (McHugh 1998, 165). Thus, "honor can accrue through association and dishonor can contaminate...if improprieties are known to have taken place in one household, lineage members...may distance themselves from this household" (McHugh 1998, 165). *Ijjat* establishes a fragile morality that is in constant reference to those around you. Liechty comments that this is especially true for those members of the middle class, of which most drug users are members. Liechty argues that: "Middle class people are those in-between, those neither corrupted by deprivation, nor debauched by excess. The middle class is "tied down" by the "restraints" of the social order" (Liechty 2003, 69). Due to this instability, immoral acts by family members can have catastrophic effects on notions of familial prestige and placement in the community. As a result, when immorality is present, the immoral person must be placed at a distance to maintain a family's status as honorable people.

The spatial relationship between a dishonorable individual and those associated with them is a major part of the logic of addiction treatment presented by private centers. In private center narratives, addiction is a behavioral defect that requires treatment outside of the home and is a disease affecting the individual and the family. When discussing who brings students to

DCN with Mr. Shamsher, he stated that: “The family has to get involved with it. The family is the one who is concerned about them.” In this narrative, substance dependent individuals do not have the tools to care for themselves or request help, their family members manage their communal identity relative to the potentially damaging acts of the diseased daughter or son. Mr. Shamsher discussed the fear associated with addicted children when talking about individuals returning to the home “They finish the course, then they work one or two months in a different department. Then we ask the family if they are ready. First just at night then during the day. In many cases family says no, we are still afraid of him. In that case we try to give technical education and send them abroad.” In Mr. Shamsher’s understanding, the fear of the damaging presence of an immoral child is solvable with distance.

> We try to tell the parents to send them to Arabic countries. One, there is no drugs on that side of the world, drugs are hard to find there. Second, they can start earning money and surviving... So we give them education or training, make them able to stand on their own feet. That is one of the reasons for our success. Give them something to do instead of watching money slip away and sit at home doing nothing.

Private clinics provide space between immoral actors and those who they could potentially harm through shame producing activities. As a peripheral and exceptional space, clinics are outside of cosmopolitan social and juridical zones. They are made to create individuals in-line with identities of moral citizenship by any means. While on the symbolic side of the violence continuum, these constructions both limit the real-world capacity of those labeled ‘addicts’ as well as connect to interpersonal acts of physical violence which cause human misery in the rehabilitative context.

Advertising

As NGO’s which run as for-profit businesses, private centers have the potential to amass large sums of money through the ‘donations’ they take from families to treat patients. This

allows centers to run massive advertising campaigns, which feature newspaper ads, radio spots, and even a TV show. When I asked Mr. Shamsher about what he hopes to accomplish with DCN's TV show he told me

> The goal is: 1. To make aware to people that DCN is there, the major objective is to educate the people so that they will not fall down in drugs...There is no program from the government, none from local government, not any from the other centers. DCN TV reaches 12 million people per week telecast in Nepal and England into Nepali communities. 10% objective is to give people an idea about rehabilitation success stories 90% is to protect the people from drugs.

In the realm of television broadcasting, DCN TV does not have competition from other centers, meaning they can run their program to create an uncontested narrative of what addiction and treatment is. Mr. Shamsher's show gives him a wide audience to consume his center's specific view of what drug addiction is and how to treat it.

I worked with a friend to translate a few episodes of Mr. Shamsher's show to see how he was portraying the treatment provided at DCN. The first episode we watched focused on the story of a young man being raised by his mother because his father worked abroad. He began using by smoking ganja before moving to harder drugs as he got older. His mother noticed that he became thinner and asked her for more and more money from her strained pocketbook. Eventually, the young man is kicked out of school for showing up intoxicated to class. His mother frantically called DCN and asks what she can do, thankfully DCN agrees to take the young man free of charge[2] and admits him to the program. After completing the program, the young man is drug free, stable, and prepared to contribute economically to his struggling mother. The family harmony is restored thanks to the rehabilitative work done at DCN. Another episode discussed how families attempt to cure addiction by sending children overseas or marrying them off. Mr. Shamsher the explains that DCN's treatment is the only one that is really proven to help

[2] In my experience with DCN graduates, none had received free treatment, most lamented the center's high cost.

people quit drugs, as shown by several scripted success stories he then details. These stories follow a similar narrative to the other episode, in which a concerned parent saves their child from death by sending them to DCN.

When I asked my friend, who had limited experiences with drugs and addiction, how he thought addiction and addicts had been defined in the program, he told me:

> Addiction is defined as being a way of avoiding responsibilities in life; enjoyment; not caring about others and low willpower. The addicts are individuals who are not caring about their families and their wishes. They do whatever they feel like, whenever they feel like it, and not care about taking orders from anyone. They are selfish individuals who do not like to take permission while doing anything.

This program has a clear audience: parents. The show's depictions play on Nepali tropes about addicts and their danger to both familial pride and monetary wealth. In the narrations, families diagnose problematic young people and explicitly blame those afflicted with substance dependence for their illness and the behavior that accompanies it. Immoral behavior resulting from drug abuse becomes the main factor in breaking up otherwise happy families. The immortality of addiction combined with parent's fears for their children's wellbeing necessitates the treatment provided by DCN. The narrative always ends with an individual who is 'free' from addiction, fully cured through the DCN's therapeutics. Mattingly describes medical narratives as "stories of other people's stories" which have "no "bare facts" and...offer a double distortion" (Mattingly 1998, 32). Through their weekly TV show, DCN narrates an addiction that speaks to tropes of dangerous youth and familial pride and is also curable, demonstrative of DCN's power to create and distort the lived experiences of lives marked by addiction. The way addicted individuals are portrayed justifies their removal from family life and the accompanying loss of their biological and sanitary citizenship.

Addiction and Citizenship

The politics of shame, exclusion, and exception discussed above and their relationship with the creation of addicted subjects can be further explored through an examination of how authors approach the topic of citizenship. Citizenship has been examined in a variety of contexts and scales but generally refers to who can make what claims to the services and protections of the state. Citizenship is tied to notions of nationhood and claims of liberal morality and is thus cosmopolitan in scale (Kymlicka 2001). As such, citizenship can be granted and revoked through behavioral attributes. The intertwining of citizenship and morality incorporates Fassin's concept of the "politics of life," which "are politics that give specific value and meaning to human life... the evaluation of human beings and the meaning of their existence" (Fassin 2007, 500). Using the conceptual apparatus of "the politics of life" allows citizenship to expand beyond bare political voicing into the value that is placed on lives and an individual's ability to control the workings of their world.

Both Rose and Novas (2004) and Das (2011) build the concept of citizenship outside of simple democratic participation. Das comments on the development of the overlapping realms of citizenship, the state, and exception, reflecting that "it is the way that notions of life and law move in and out of each other that forms the texture of moral claims" (Das 2011, 324). Specifically, Das examines how laws propagated by the Hindu lawgiver Manu, define "how the social order is to be restored when an act seriously violates the idea of dharma, not as caste specific rules but as violating the sense of life itself" (Das 2011, 323). Citizenship in this manifestation is related to the maintenance of a specific moral order. Das builds on this point to define citizenship as a status that must be maintained and nurtured, rather than a fixed category of national personhood, especially for the poor and disenfranchised. This definition implies that

the benefits that accompany citizenship can be discontinued if proper morality is not adequately maintained (Das 2011). Rose and Novas's conception of biological citizenship is useful for understanding the consequences which accompany the inadequate maintenance of citizenship status. In their definition, "Biological citizenship can embody a demand for particular protections, for the enactment or cessation or particular policies or actions, or… access to special resources" (Rose and Novas 2003, 5). The tenuousness of citizenship in relation to the concept of biological citizenship makes "the politics of life" within which noncitizens operate inherently dangerous. It allows for the revocation of claims to safety through the definition noncitizens as an immoral minority, not worthy of the benefits and safeties afforded to citizens.

Briggs (2003) expands on the above notions of citizenship to build health and hygiene into understandings of citizenship. In his description of a Cholera outbreak in Venezuela, he explains that identifying someone as what he calls an "unsanitary citizen" had drastic implications for the types of social and civil rights a person had access to. The qualifiers of a sanitary citizenship were similarly culturally specific to those I have described above in that they represented an amalgamation of public health discourse, political agenda, and racial politics in identifying who had a specific medical relationship to their bodies. The opposing definitions of sanitary and unsanitary citizenship are surprisingly relevant to the Nepali case. As Briggs describes: "sanitary citizens- those who contribute to the body politic by internalizing scientific understandings of health, disciplining their bodies, and sanitizing their environments. Opposite these populations are other populations that threaten the health of sanitary citizens" (Briggs 2003, 257). Sanitary citizenship allows us to connect the concepts of health, morality, and contamination, illuminating the ways in which private center addiction narratives marginalize substance dependent individuals and justify overlaying violence and treatment. In connecting

substance abuse, morality, and health, substance users lose their ability to make claims of safety and civil rights on the state. Private centers can exert biopower in tandem with the diffuse Nepali state. They define addiction, justify treatment, and commit violence, all within the everydayness of the existing status quo of medical privatization and diffuse governance.

Evidence-Based Care

In the private center's formation of addiction treatment, addiction is not a medical illness to be treated in the hospital or a social problem to be dealt with at home, but a behavioral problem that must be addressed with their treatments. The center becomes a place where addiction can be 'cured' through the dialogues perpetuated by private centers and the co-option of medical vocabularies of certainty. While large advertising budgets allow private centers to control dialogue regarding addiction in the public sphere, they are not the alone in attempting to create addiction in the Nepali public imagination. Psychiatry, a discipline struggling to find its own foothold in the Nepali medical field, voices an alternative narrative. DCN and doctors providing care based on principles of "evidence-based" techniques represent two poles of treatment; one, the complete privatization of care, outside of governmental structures, the other advocating for the biomedicalization of treatment through its incorporation into medical governance. As I discovered through my work with some of these psychiatrists, the negotiation of what is and is not medicine shapes the delivery of treatment for mental illness.

The unstable place of medicine within mental healthcare was revealed to me on my first visit to an urban Nepali hospital, when I met Dr. Thakur. While she doesn't work directly with substance abuse, she is a part of the beginnings of what she hopes will be the more widespread use of formal mental healthcare services in Nepal. She described the difficulty mental health professionals faced in Nepal due to a lack of mental health infrastructure. "This is one of the best

hospitals but we are very few. We don't have counselors who are working in the community, just around 30 psychiatrists in the country and about 10 or 15 abroad. There are about 30 clinical psychologists from this institute, which is the only institute. So we are the services and I'm not only talking about addiction, I'm talking generally about how it is." Dr. Thakur discussed the instability of the place of mental health services in Nepal, stating that they are underfunded and underutilized. This is troubling concerning the increasing problem of suicide related to issues of migration, familial turmoil, and drug and alcohol use in Nepal (Hagaman et al. 2018). In referring to the roles of both traditional healers and private centers, Dr. Thakur reflected that "Healing is in the mind you know (laughing) they are doing the psychologists role. But, again with a big 'but,' this work, the causes of addiction and stress, they don't get cured. So it is restricted I must say and that has been a really huge challenge to us." Other forms of mental health provision challenge the hegemony of biomedical psychological treatments. The small number of trained professionals and the lack of cultural acceptance means that psychiatric forms of care are in competition with other sources.

This is especially true regarding substance abuse treatment, a particularly lucrative sector of mental healthcare. Private centers and public sources of treatment vie for public opinion regarding what constitutes treatment. However, the rules of this competition are not the same for both parties, as one side attempts to market cures, and the other is bound by medical ethics and the principles of evidence-based reasoning. The treatment provided in government sponsored clinics, in the form of methadone, buprenorphine, and de-addiction treatments operate under the principles of evidence-based medicine. In a seminal piece in the canon of evidence-based medicine, Sackett et al. (1996) explain that:

> Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by

> evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients (Sackett et al. 1996, 72).

In OST, patients are given doses of methadone based on personal medical history and drug use habits, combined with the medical conclusions on proper dose determined by body type and the type of drug being abused. Psychiatrists at TU also discussed travelling to conferences and exchanging papers with international scholars often to stay as up-to-date as possible with current findings regarding treatment, another pillar of evidence-based care. While evidence-based drug rehabilitation has techniques and tenants, it does not provide cures, as it is based on the NIDA definition discussed above which constructs addiction as a brain-based chronic mental illness. This construction implies that addiction must be consistently and diligently managed, rather than behaviorally cured. The TU and OST staff thus do their best to treat addiction in its medicalized rather than its moralized form.

While their approaches may be methodologically and technologically current, spreading these findings about addiction and proper treatment to the public has been difficult. Regarding public outreach, Dr. Sagun explains that there are "a lot of drug related and oriented programmes which are designed to inform, educate, and communicate about the problems of substance abuse to teachers along with other school mental health programs. Also to police personnel to ensure that addicts are viewed as patients rather than criminals… but there is a lack of sustained funding." Dr. Sagun was referring to programs like the SAATH, which was formed to educate youth about the dangers of drug abuse. The inconsistent funding of such initiatives makes the dialogue of evidence-based care and the disease model of treatment a message that does not have a wide reach. These initiatives also tend to be focused on educating youth regarding the dangers of drug use, rather than parents who will be making decisions on whether to send their children

to private treatment or to OST. While narratives of evidence-based care may be the global medical standard for treating addiction, when care is placed on the neoliberal marketplace, business savvy and advertising budgets rather than health efficacy determine the public's outlook regarding the proper way to heal.

Loaded Numbers

Private centers present themselves as curative spaces for an illness affecting the social and physical body and are unlike other medical entities. Centers like DCN operate within an in-between, offering treatment that is technical enough that it must be paid for, but not so much that it might fall under the purview of medical regulation. Existing on the periphery of medicine, private centers use the vocabularies and some of the techniques of biomedicine, but in discourses surrounding care, DCN spokespeople are quick to separate treatment from psychiatry. Not only is the addiction described by DCN curable, according to the statistics they advertise, being cured is almost guaranteed. This guarantee is expressed through the certainty of numerical data, the origin of which is questionable. Returning to the episode of my tour with Prashant, I asked him how DCN compared with other facilities in regards to its treatment method and success rate. He explained:

> Prashant: There are three types of rehabilitation centers: One, the government run facility, where someone stands with a gun at the gate like a prison kind of thing. Second is a Narcotic Anonymous disclosure type of thing. Third is DCN which is the only one. The other two have a success rate of 2-5%. DCN's success rate? 80-85%
> Robin: Wooooow
> Prashant: And that is because there is no 100% in anything. I can say the 15% they are in the category of people who will never and cannot recover. But we are trying out best. That is a good success rate in this sector.

I found this number surprising because the NIDA projects that around 50-60% of users who have undergone inpatient treatment eventually relapse (NIDA 2015). For example, the state-run clinic where I worked in Hawai'i consistently had over 80% of their clients relapse; it

happens so frequently the tendency to relapse is built into the biomedical definition of the disorder. The level of rigor with which DCN was treating their data collecting process was unclear. When I asked Prashant about how they monitor for relapses he stated: “We keep the contact and stay connected with their parents. The course is about six months long, and after this we don’t just send them on their way. No, we keep them inspected.” When I told Dr. Sagun about the success rates DCN was claiming he exclaimed: “How do they measure that? These things do happen in countries like ours where people with influence can just make things happen.” Manoj shared his disbelief: “I don't believe in the 80% success rate because I have proof! People take six months there, after eight months the same people come over here! So I have proof!” Since DCN operates within a peripheral space of exception, they can co-opt the vocabularies of certainty of medical treatments without being subject to the rigorous burdens of proof which go into their creation. In using statistics as evidence for the supremacy of their treatment, DCN goes beyond advertisement into the creation of medical truths which reify their narrative of addiction.

Briggs (2003) explains that the story of the Venezuelan Cholera Outbreak of the mid-90 was told by-in-large through statistical imagination. In this case, government-controlled sources of data collection told a specific story through the statistics they shared while simultaneously reifying the structure of the state as an entity that could collect data and enact public health policy during a crisis (Briggs 2003). Other authors have described the “Age of Statistics” as “a recent emergence of faith in statistical measurement as the basis for an objective and necessary science of society” (Urla 1993, 819). Alanso and Star state that “where the statistical collecting and reporting agencies enjoy a reputation for professionalism, their findings are commonly presented-and accepted-as neutral observations, like a weatherman’s report” (Alanso and Star

1987, 1). Statistics derive their meaning through what they do and do not describe. Since statistics give the appearance of being apolitical and unbiased, they can produce events and populations in a specific, seemingly undeniable light. Centers can prove the efficacy of this construction and the methods they use to treat it through co-opting medical vocabularies of certainty, like statistics, which present their construction and its supposed success as naturalized.

Addressing the Competition

While private centers attract more clientele and can secure much more stable funding through the consistent influx of patients than government funded OST, OST is a free service and private centers can be extremely costly. DCN charges a significant amount for their in-patient treatment and must contend with the potential of OST clinics attracting their clientele. Above I have discussed ways in which DCN uses media and statistics to create a specific version of what addiction and treatment is. In separating themselves from OST forms of treatment, DCN representatives focused on explaining what treatment was not, in particularly that treatment is not found in the tools of psychiatric medicine.

An argument I had during my tour with Prashant about depression was revealing of how many private centers create methodologies to treat behavioral problems. He stated that with depression, like addiction, “We can treat the depressed person through getting them involved in an activity where they will get serotonin. Let’s sing, dance around, he will get out of the depression. That activity substitutes the medication.” While some private centers use (and abuse) medications which lessen the pain of detox, the actual treatment is in activity which teaches proper behavior. Methods of treatment are thus not explicitly defined by what they are but rather by what they are not. Prashant explained that detoxing was not enough to keep someone off drugs, sobriety is accomplished through behavior-adjusting therapy: “They go to the life skill

course...This is where they learn morals, how to act in society, how to respect the elders, what is love, what is hate… all of these types of things. After the course they will properly understand that." Prashant went on to say that: "If people are on psychiatric medication they are on a narcotic. Anything that makes our nerve system numb or intoxicates us makes us dull. These medications don't work." In the eyes of private centers, treatment is teaching behavioral norms rather than ingesting medication.

Private centers go to great lengths to narrate their treatment as "not psychiatry." In the eyes of psychiatrists, this is largely because evidence-based psychiatric care, provided at OST centers, is free and would cut into the private centers' bottom line. Dr. Sagun told me that "You will find examples of an agent from a rehabilitation center coming to an OST center and saying many bad things about methadone and buprenorphine to their families. Because buprenorphine is given by the government for free, but you have to pay some amount to get into the NGO, it's all a business." These centers create a vision of behavioral treatment that is generally, but not always anti-medication, but that is assuredly anti-psychiatric. This separation is also rooted in the lack of regulatory measures, Dr. Sagun reflected further: "As a scientist, I have a whole community that will question my approach and examine the ethics behind it. Who questions the methods of private centers?" Through rejecting the tenets of psychiatry and focusing on behavior rather than bodily illness, private centers create treatment that is medical enough to take place outside of the family, but not to the extent that it is subject to 'scientific' scrutiny; treatment on the periphery of the medical.

Discourses of Exception

The place of the private center, on the periphery of medicine and out of the sight of state regulation, allows private centers to assume the authority of medical professionalism without

being subject to the burdens of evidence-based care. As a result, addiction can be narrated in a way that appeals to cultural tropes and norms that are specifically Nepali. DCN and other private centers have created addiction is as a behavioral malady resulting from personal immorality. This type of immorality and its potential to damage the moral standing of the community from which the substance dependent individual is from justifies the revocation of both sanitary and biological citizenship and internment in private centers, where personal wellbeing and agency are no longer protected by the state. While counter narratives of evidence-based medicine coming from Nepal's rising generation of mental health professionals are also present in addiction discourses, private centers have substantial funding to devote to advertising which simultaneously promotes their own treatment, while questioning the use of medication in addiction treatment as 'part of the problem'.

Mr. Shamsher's moralizing rant continued for a seemingly endless two hours. I sat in front of everyone, petrified and ashamed, but not able to show it. I pitied myself for becoming a piece of propaganda, for being a tool for another's scheme, a piece in a puzzle whose picture had not yet become clear. As I pieced together what Mr. Shamsher had said about the immorality of drug users and how his speech must be making them feel I caught the eye of one of the young, yellow vested men sitting in the front row. He shared the same general appearance to the other men with his vest and his buzzed haircut, but his face told a different story. A black eye was hidden under the brim of a cap, one given recently enough to still be swollen with puss. My internal dialogue regarding the politics of representation and the violence that accompanies it was silenced by the specter of physical violence. The reality that representations can hurt, can maim, was beginning to come together, as Mr. Shamsher made a quick exit; he had to make a presentation for International Drug Awareness day.

Chapter 5. Violence as Treatment

> I was there for two years, and I got depression from this. That is the main thing, a long period of time you have to stay there and you cannot leave, they will not allow it. You pay each month and it is a lot of money. I stayed around nineteen months and around 7 lahks Nepali money they took! Two years is a very long time, if it was three or six months then fine, but in same house? In the same program? Two years is very long. Many people go into depression... Many people stayed as long as I did.

Dhiraj spoke softly, his voice trailing off into the ambient noise of the afternoon. I reminded him that we could stop our conversation whenever he liked, but he continued to reflect on his time spent at DCN. Despite the physical abuse he suffered and witnessed there, Dhiraj was most upset about the time he had lost, two years interned in a rehabilitation center which was charging his family exorbitant sums of money each month. He was not permitted to leave until he had satisfied the staff at DCN that he had "recovered." When he finally did, he was unable to stay sober for long, which resulted in his eventual entrance into OST treatment.

Dhiraj's reflection on his lost time and the depression that it caused him point to a challenge when discussing violence in contexts of incarceration; the difficulty in determining where violence begins and ends. The types of torture and direct physical abuse administered in some private rehabilitation centers defy adequate description and resist temporal bounds of experience, remaining with victims long after they have left spaces of internment (Herman 1997). In these contexts, violence also takes on banal forms of everyday boredom and gradual dehumanization. Angela Davis discusses the forms of violence female prisoners are subject to in US prisons. She explains: "We tend to think about torture as an aberrant event. Torture is extraordinary and can be clearly distinguished from other regimes of punishment. But if we consider the various forms of violence linked to the practice of imprisonment - circuits of violence linked to one another - then we begin to see that the extraordinary has some connection to the ordinary" (Davis 2011, 62). Davis's description connects to Scheper-Hughes and

Bourgois's violence continuum, demonstrating a thread between banal and extreme forms of violence (Scheper-Hughes and Bourgois 2004). Not all acts of violence which occur in the rehabilitative setting are as severe as torture, but the link between banal and extraordinary violence is palpable in the rehabilitative setting as well.

Rather than define what acts can be identified as torture, I focus on the ideological underpinnings of the violence that takes place at DCN and numerous other private centers. I approach the relationship between addiction and institutionalized violence as Angela Davis has discussed prison violence in that "rather than rely on a taxonomy of those acts that are defined as torture and those that are not, it may be more revealing to examine how one set of institutionalized practices actually enables the other" (Davis 2011, 63). In other words, how does the partial medicalization of addiction and its location in private centers exercising scientific and medical sovereignty connect to torture and everyday violence within treatment settings? Underlying experiences of private center violence is that these acts take place in pseudo-medical spaces of exception, where the efficacy of treatments does not have to be proven to the standard of medical institutions. Within these spaces, treatment mechanisms are overlain with punishment, for failing to follow the behavioral treatment mechanism, or as the treatment mechanism itself.

Overlaying treatment and punishment is hardly a new concept, and has been investigated in the field of rehabilitative psychology extensively (Helleck 1971; Axelrod 1983). In the psychological perspective, overlaying punishment and therapy is part of a project to "develop a technology that will improve the human condition" through the controlling of "behavior which are destructive to oneself, others, and the environment" (Axelrod 1983, xi) This discussion underlies the activities conducted in jails and prisons with the hope of reforming inmates. Much

of this literature has included the medicalization of what was once seen as social disorders into mental illnesses and the immorality of criminalizing sufferers (Gostin 2007). The coerced nature of this style of rehabilitation has caused others to find it violent, even on the far side of the treatment spectrum. In her paper examining a feminist approach to the treatment of pregnant addicted women, Iris Marion Young found that despite a rehabilitative agenda, individuals from law enforcement officials to social workers operated with the assumption that women must be punished for subjecting their unborn children to the dangers of substance use. She argues that embedded in punitive legislation involving addicted mothers are the principles of deterrence and retribution. Deterrence policies operate under the assumption "that it is within her power to refrain from taking drugs if she judges that the costs are too high" (Young 1994, 37). Retributive conceptions contend that "these women ought to be punished and threatened with punishment because their wrongful actions deserve sanction" (Young 1994, 37). Thus, even though "addiction implies a limitation on the free agency, and thus responsibility, of the addicted person" the condition is penalized along with being treated. While Young contends, that "criminalizing drug addiction violates a prohibition against cruel and unusual punishment," the relationship between deterrence, retribution, stopping addiction remains, reinforcing the connection between violence and treatment (Young 1994, 37).

In my analysis, violence is not examined as an isolated act of inexplicable aggression. Rather, it is a consequence of a diffuse government which has permitted centers to partially privatize sovereignty, the dehumanization of drug users in private center addiction discourse, and the classification of addiction as a behavioral illness, all of which blur separations between treatment and punishment. In defining private centers as spaces of curative exception, care providers are licensed to manipulate the body in the same way a doctor might. The use of therapy

and punishment play on Foucauldian tropes of biopower and bodily surveillance, at their worst crossing boundaries into the inexplicability of torture (Foucault 1995). I discuss the ways in which punishment and treatment mingle through telling three stories of rehabilitation, all of which encounter violence in different ways. These narratives illustrate the separation between what private centers claim to do, as described in the previous chapter, and the lived reality of their treatment. They also illustrate the relationships between the everyday violence of treating addiction as a moral failing and the exceptional violence of physical and emotional abuse resulting from the loss of biological and sanitary citizenship.

Violence and Meaning

Previous chapters have examined the structural violence side of the violence continuum involved in the ways drug users have lost rights to biological citizenship and claims to state protection. I will now turn to the consequences of this loss for drug users interned at particularly problematic institutions. This chapter will confront accounts of beating, mental and physical torture, and suicide to demonstrate the human cost of the privatization of addiction treatment into spaces of exception. Violence in this setting is profound because it is made legitimate through connections, however fuzzy, to medicine and treatment. Malicious acts are committed in private centers within the framework of curative therapeutics. When framed through the lens of curative treatment, violence takes on a specific meaning and purpose.

The relationship between drug rehabilitation and violence is informed through anthropological analysis of other violent acts. Violence is an anthropologically slippery concept, present in many forms of modern life, meaning its exact definition may change when examining disparate cultures and events (Heelas 1983). Above we have discussed the historical mechanisms and neoliberal economic logics of personhood which have allowed for the revocation of

biological citizenship for Nepali substance abusers. Here we will examine overt violence, acts which directly cause human misery and rob individuals of their physical and mental health. While this definition of violence may appear straightforward, it is dependent on an understanding of violence as a concept that can be universalized across cultures.

Anthropological analysis of violence relies on Weberian understandings which allow us to “grasp violence as meaningful action” (Krohn-Hansen 1994, 377). Anthropologists have discussed that definitions of violence are often culturally bound as far as which acts are considered violent or harmless (Krohn-Hansen 1994). One way scholars have dealt with this dilemma has been through defining acts as violent based on the perception of participants. Heelas has remarked that there are two perspectives of violent acts, that of the victim and that of the perpetrator (Heelas 1983). This is complicated by situations in which neither perpetrators or victims deem a harmful action ‘violent’ and implies that understanding violence is bound culturally and cannot be generalized at all. To make analysis of violence more generalizable, Riches (1986) examined the triangle of perpetrator/victim/witness in his work questioning the practical and symbolic uses of violent action (Riches 1986 in Krohn-Hansen 1994). This examination of multiple perspectives allows for a fuller picture of the relationship between what Farmer calls “everyday violence” and overt acts of aggression (Farmer 1996). To use Krohn-Hansen’s words, “it is reasonable to speak about the number of deaths per day due to starvation resulting from advanced capitalism and trade policy; but the lethal capitalist relationship is also managed by actors” (Krohn-Hansen 1994, 373). In this spirit, this chapter examines violent acts both as real actions that are perpetrated to inflict physical and mental harm as well as the social processes to which these acts are connected.

Medical Violence

In the Weberian spirit of attempting to examine violence as meaningful action, we must confront the setting in which the violence described below takes place. This setting, the private center, is one that describes itself as a place of curative therapeutics. As I have shown above, the creation of the private center on the marketplace of care relies on the use of the vocabularies and some of the techniques of biomedicine, without being subject to the same regulatory mechanisms as most biomedical spaces. This places those providing the care offered in private centers in a unique position of power, making the private center-substance dependent person relationship like that of the doctor and the patient. This power laden relationship can have drastic implications for bodily governance.

The connection between biomedicine and the reification of hegemonic power through the de-socialization of poor health makes this relationship especially power laden, as purveyors of biomedicine transpose dominant cultural norms onto the practice of healing (Flic 2004). Biomedical control of this sort manifests itself in practices such as gender assignment surgery, where medicalized notions of normalcy pressure parents into gender assignment, permanently altering the sex organs of the individual and enforcing notions of sex as productive and heterosexual (Karkazis 2008). Rayna Rapp examines the ways in which cultural normativity involving gender, race, and class divisions influences medical recommendations about terminating the pregnancies of mothers with disabled children, and the emotional trauma endured by parents forced to make these choices (Rapp 2000). These examples are particularly unsettling because they arise from the medical profession, a place meant to exist for the explicit purpose of promoting health. They demonstrate the immense power medical practitioners hold over bodies and lives as both healers and purveyors of hegemonic culture.

Kothari and Mehta state that "Medical violence is a curious product of the physician's arrogance, trappings of technique, and the laity's faith that medicine can solve all problems" (Kothari and Mehta 1988). Faith in the biomedical project coupled with the ability of physicians to intervene in an ill person's body is foundational in the creation of medical violence. Judith Shapiro discusses the everyday violence of the medical setting. Her discussion of violence is interesting, as it defines violence based on harm done unintentionally. Using this framework, we can examine supposedly benevolent acts of caregiving beyond the curative mission of biomedicine. When examined through this lens:

> There are multiple examples of violence in medicine. From the dismembering of the human body that occurs in the first year of medical school during the anatomy course, to amputations, surgeries, and diagnostic or interventional procedures that cause pain, including the numerous uncomfortable and sometimes dangerous side effects of drugs intended to heal, there is a brutal dimension to medicine" (Shapiro 2018, 2).

Drawing again on the work of Angela Davis, she states that in female penal institutions "if uniforms were replaced with civilian clothes-the guard's and the prisoner's-the the act of strip searching would look exactly like...sexual violence" (Davis 2011, 62). In extreme cases of medical violence and coercion, one could say the same of violence within spaces of treatment. While the medical violence described above is present in private rehabilitation centers, the narratives presented in this chapter provide a glimpse of pseudo-medical violence: Interference with an ill body that is permitted through narrative connections to biomedicine, but without biomedicine's regulatory functions.

Three Stories

To engage this topic, I will examine the rehabilitation experience of three men who were treated at DCN and other facilities. These narratives reflect the spectrum of violence experienced in private centers, from the everyday to the extraordinary. They also explain the ways in which

violence is understood by former patients. In some cases, it is seen as a necessary punishment for not following the rules, in others, it is difficult to extract the violence from the mechanism of treatment itself. These stories show the ways in which patients' ability to dissent to the violence they are subjected to is limited. Some can leave problematic centers through family connections and trickery. For others, the only way out is to convince staff that they have internalized the lessons of treatment, which often implies submitting to violence. These stories demonstrate that treatment center violence intimately intertwines punishment and therapy, erases the ability of patients to dissent, and in some cases causes patients to internalize understandings of drug users as morally flawed. I will begin by sharing what Sunil and Dhiraj explained to me about their treatment experiences before placing them within the frame of pseudo-medical violence. I will then examine how Arbin told his story through the lens of symbolic violence.

Sunil

Sunil and I spent a few hours going through various stories about his detention in a variety of private centers. He is a quick talker, but the type who conveys his sincerity and emphasis with prolonged periods of eye contact. He commuted to work and visited the OST center on his motorcycle, and from the intensity of our conversations and his stories about fleeing from the law, I imagined he rode very fast through streets wet with monsoon mud. Sunil has endured a tremendous amount for a young adult, and I wondered if it was that youth that made him so able and willing to describe traumas he had experienced and witnessed with such detail. Sunil was by far the most open ex-patient I met with during my fieldwork. His openness at times seemed to be a part of his own process of understanding his story; narrative would be broken up by opinions, insistences, and accusations. Despite his exuberance, his experiences left him with what seemed like a yearning for quietness. I once asked him what the best place he

could imagine to recover would be. He responded simply: “One person, one cottage, each cottage a little far apart. A nice place with books, yeah.”

Sunil spent time at DCN and other clinics before finally achieving lasting sobriety through OST therapy. Before Sunil’s first experience with the police, described in chapter two, he had spent time at DCN. This was prompted after his father noticed his declining grades in school and said he was going to take him to treatment. At DCN the director of the center, “He said if your son is in here, he will be alive, if he is not in here he is dead.” While Sunil’s father was convinced, Sunil failed to pass the medical examiner’s test and had to wait a few weeks because he was taking medicine for an illness. When he was finally admitted, he enjoyed some of his life at the center. He explained to me that some of the therapy “Yea it worked, when I came back I knew to clearly understand words before I moved forward, anything I didn’t know, I looked up in the dictionary. The other thing was that the food was good.” Sunil thought that if he could work through the program he could improve his studying skills and attend university in Australia, like some of his friends had done.

However, a few weeks into the program Sunil had his first problem when a graduate told him “I don’t like your face” and made him stay in what he called the extension room where “there is only room to (lays down in the fetal position) and this (crouches, standing up halfway). Too small! They gave us punishment like that. I was in that room for fourteen days...’I don’t like your face.’ For only that reason he kept me fourteen days in there.” I asked it what it was like, to spend so much time in a place like that. Sunil said: “I was totally mad! I didn’t do anything, they didn’t give me newspaper, they didn’t give me magazine, nothing! Only I had one pen, a friend gave me so I would write on the walls. It’s like this: three sides wall, one side steel bars, locked.” While Sunil expressed the discomfort he felt in the extension room, he had witnessed worse. “I

saw the first day two boys escaped from there and they caught them, and in front of my eyes they beat them with fifty slaps. It was my first day... they got fifty slaps and then we went to lunch. Then they came after with a belt and they took the belt to them. After, they took the two boys and they took them to the extension room for three months."

After his own stint in the extension room, things began to go downhill for Sunil as well: "They treated us like slaves, everything we would do, everything! Go to that toilet drain and make it clean by your own hand with no gloves! I have done that a lot there. It's the truth!." Unwilling to endure the ill treatment he experienced at DCN, Sunil decided to escape: "I was able to get out then because I pressured my parents. I said to the graduates that 'I saw a bad dream and I worried about my mom and I want to talk with my parents, they said 'ok.' You have to be clever in there. If you are not cleaver, you will not go up, you will go down down down." Sunil used his phone call to convince his parents to take him out of DCN.

As discussed in chapter two, Sunil learned how to inject heroin at DCN. This newly formed habit led him to have further problems with his family and the police, eventually landing him in another private center near the famous Kopan Monastery. While Sunil expressed anger when discussing his time at DCN, this other center provoked fury to the point of confusion. "They could do anything, like a prison, anything for no reason. Whatever they want to do, because no one is there to stop them." Sunil enjoyed the instructional part of his time at DCN, but in this center therapy was given as violence and humiliation: "That one rehab is so cruel...They treat people like animals, they gave us activities just like animals. Like they said your nose will be touching like this here, for four hours (standing against the wall tip of the nose touching it). How can we stay like this for four hours? There is physical punishment too. They could do anything." While Sunil was able to convince his parents to rescue him again from this

center, others stayed and endured the abuse. "One boy ate a tube light to do suicide, because there is nothing." In this final short episode, which Sunil did not expand on, the desperation of being placed in a private center is revealed. The seeming endless nature of the therapy, the lack of control given to individuals, breeds helplessness. In extreme cases of helplessness, when individuals are not as resourceful as Sunil, young men can be pushed to take their own lives. The ability of private centers to create addicts as immoral and behaviorally defective does not just do work on the perceptions of parents, but on addicted individual's perceptions of themselves. Dehumanization and the hopelessness present in some of the most problematic centers has led to multiple suicides.

Sunil's entries and exits from therapy clearly demonstrate the ways in which the overlaying of the behavioral model of addiction with loosely defined concepts of medicine allows treatment to be delivered as violence. This delivery can occur directly, such as the 'focus' training at the Kopan center, where he was forced to stand with his nose against the wall for long period of time. It can also happen indirectly, such as the punishments given to Sunil and others because of not conforming to the behavioral expectations of the center. In both cases, violence is enacted in hopes of transformative change, that an individual will alter their behavior with the unpleasant memory of the extension room, or the fifty belt lashes that resulted from defying the rules of the center. In this way, punishment is built into constructions of therapy. Through principles of deterrence and retribution, addiction is literally expected to be beaten out.

Dhiraj

As discussed above, Dhiraj was unable to engineer a way out of DCN and was interned there for two years, subject to the complete regimen of their treatment plan. DCN's course of treatment involves an initial detoxing period, a moral education phase, an extended sauna

assisted detoxification phase, followed by a final job training phase. Dhiraj's trouble with DCN began in the initial phase, where the anti-psychiatry logics of care prevented the use of pain medication: "It was very painful for me to come out of withdrawal. Taking only this (vitamins), it was very painful for me to come out. If you experience pain they just rub your back and give some vitamins. But it is not a pain killer, not like that. In other rehabs they give something like substitution, but in DCN they give only vitamins." His problems persisted in the sauna segment of rehabilitation, where "sauna treatment was good also but it did not suit me. It was harmful to me." Both elements of detoxification caused Dhiraj pain through their therapeutics. The conception of the addicted body, loosely attached to biomedicine but expressed in biomedical terms, allowed for this unnecessary and ultimately unsuccessful style of treatment to be given.

Diraj didn't mind the educational component of DCN's therapy, but its lack of relevance to his post-treatment life added to his general state of depression: "When we came out of the center, we cannot apply what we learned in those books. The things I learned in DCN, I cannot apply them outside. I don't know exactly why not, just it is difficult." As a center which uses the language and thus assumes the authority of biomedicine, DCN could not be held accountable for individual patient failures; it is almost never the fault of the center, but the fault of the flawed individual. This logic allows DCN to remain unaccountable for the unnecessary suffering its treatment method causes. Dr. Sagun once described to me the ways this narrative erases the actual clinical experience of patients in private centers. Parents are "succumbing to the promises that these centers of care are providing...the flashy and glorious ones, they come forward. In the end, no drug user is going to come up and say 'you promised that I would not relapse,' If he did they would say, we did the best treatment, this is your moral defect." Dhiraj had no outlet to describe the ways in which the detoxification methods at DCN harmed him, how the books he

read inside taught him things that he could not use to stay sober, and how he had been robbed of many Lahks of rupees and years of his life. Dhiraj was being treated for his behavioral illness, and the accompanying narrative of care in which he was treated erased his ability to dissent.

The violence occurring in Sunil and Dhiraj's narratives takes place in what I have labeled above spaces of exception, meaning they are not the medical spaces examined by Shapiro and Kothari & Mehta. The exceptional nature of these spaces, coupled with their self-identification as curative centers, makes this type of violence particularly insidious. Dr. Sagun explained this type of violence during one of our meetings, stating that within private centers "I think drug users do not have access to basic human rights. You pick me up in a van and incarcerate me in some center after one phone call. You treat me without my consent, and so many other things." As described by Dr. Sagun, the moral and behavioral model of addiction which is treated in private centers overlays treatment and punishment. In this sense, punishment stems from the naturalization of the moral self, and the need to alter the addicted body for it to return to its natural moral state. As NGO's sanctioned by MOHA to address addiction, private centers are permitted by the state to treat but outside of its regulatory mechanisms. This situation presents a different type of medical violence, in which private center employees assume the authority to interfere with the body without being subject to the same institutions and formalities as employees in the medical field generally are. Thus, while the biomedical model produces violence like that described above, fully privatized drug rehabilitation, with only tenuous links to regulatory mechanisms, engenders violence of a more overtly punitive form.

Arbin

I met Arbin through my connection to Manoj at the clinic. What I found most striking about working with him was the extent to which he seemed to simultaneously rebel against the

treatment he was subjected to while also endorsing its underlying assumptions. Arbin had been kidnapped from his home in the middle of the night and taken to DCN because of his family's concerns over his heroin, ecstasy, and ice use. When I asked him about his experience being kidnapped and taken to DCN he told me: "If there is a forcefulness I am able to go, otherwise I would not be able to go." It was almost as though he viewed what had happened to him as a liminal phase to get to where he was when I spoke with him; newly married, sober, and free. Arbin's position reflects the complexity of the process of violent behavioral modification; that while there are unified voices of opposition to the practices of dehumanization, they do not all share a common understanding of addiction.

Arbin was taken to treatment because of his abuse of a variety of substances. "My choice of chemical was brown sugar but I also took ice and ecstasy, but daily I used to use heroin." He was kidnapped and brought to DCN and he points to this as a crucial part of the reason why the therapy provided there failed for him. "I was forced to by my family. Some decide to just come. That kind of person are still sober now, they are drug free... It is a willingness program. If you apply that method that they teach there, you will surely be drug free. If you do not you will not... If someone forces you, that program will not work." In this narration, Arbin accepts the logic of therapeutics, that the treatment works but not all individuals are motivated enough to stay sober and follow the program.

Arbin explained that those lacking the willpower to follow the rules of the center were those who encountered violence. He explained that "When you stay inside the boundary… you have to obey the senior staff command, if you do not obey there are consequences. So inside you are afraid and you do not do that kind of thing." When someone disobeyed, doing things like "not cleaning the room, misbehaving, not obeying senior staff instruction," consequences ranged

from minor to severe. Arbin also experienced the same extension room as Sunil. He described it as “half a person this room and there is only a bed and all is closed and you cannot go outside. Only in morning time, one time you can go toilet, long toilet. For short toilet there is a bottle.” Arbin also described witnessing physical abuse at DCN stating that “They beat, they beat...when they call them (students) and they don’t respond. ...they will beat them for not responding.” Arbin’s narration explains violence as a punishment for being unwilling to be treated. He was careful to remind me that “if you do good in there they will not touch you, but if you make a big mistake then there is a problem.” For Arvin, the violence was not in the treatment itself, but in an individual’s own inability to follow the treatment regimen of the center.

Arbin’s understanding of addiction and therapy was clearly influenced by his time in the center. While it was OST which ultimately allowed him to achieve lasting sobriety and stability with his new wife and family, he retained the conception of drug use and users propagated at DCN. In discussing relapsing after DCN as his own failure and equating success and “willingness,” Arbin demonstrates Bourdieu's concept of symbolic violence, in which structures of power are maintained by both the oppressor and the oppressed (Bourdieu and Accardo 1999). Nancy Campbell has expanded this discussion regarding drug abuse narratives, stating that “The narratives of drug discourse do not proceed as simple discussions of ‘fact’, but instead assess the moral and symbolic value of particular paths and patterns of risk and blame” (Campbell 2000, 38). Private drug rehabilitation involves the process of losing and regaining biological citizenship, bringing into question the morality and decision-making capacity of drug users. In questioning this capacity through therapeutics, private centers inform patient’s narrations of their own stories. Individual details and causes of beginning and continuing substance abuse are

obscured by narratives depicting a linear relationship between addiction, therapy, and sobriety.

Therapy as Punishment

Sunil, Dhiraj, and Arbin's stories demonstrate the day to day violence which occurs as a person goes through private center treatment. Sunil encountered violence in both treatment mechanisms and punishment for disobeying. Diraj's body was harmed by unassisted detox and the long hours he was forced to stay in the sauna. His status as a drug user made him unable to dissent to these methods because of the assumption that the center's employees knew what was best for him. Arbin recognized the relationship between treatment and violence, and internalized the need for "willingness," both to recover from drug use and to avoid the wrath of private center employees. These three stories illustrate the ways in which violence can be given as treatment, how it is reproduced due to a lack of input from patients, and finally how it is internalized and managed by patients themselves. The narratives and quotations here do not do justice to the effects of lives which have endured treatment as violence. While all these narratives ended with release from private centers, through both legitimate and cleaver means, none of these men was 'cured' of addiction through the violence they were subjected to. What makes this uniquely pseudo-medical violence is that it is ultimately fruitless in assisting individuals to live sober lives, instead subjecting them to violence which does not inhibit their capacity to use drugs and instead causes unnecessary suffering.

Angela Garcia discusses the ways in which the combination of juridical and medical treatment of addiction places those caught in the cycle of heroin use in an endless cycle of jail, treatment, and relapse. Central to this cycle is the competing understanding of the juridical body, which is expected to govern itself to the standards of the state, and the addicted body, which is seen to have a chronic, relapsing illness. The cycle Garcia describes places addicted individuals

within a framework which they cannot escape from. This cycle of returning, to jail, to treatment, to drug use, creates addiction as endless and, when attached to colonial histories of disenfranchisement and loss, makes further drug use the only medicine (Garcia 2010). The narratives above struck me as similar to those which Garcia describes. Private centers expect individuals to self-govern their bodies with treatment methods that are obviously inadequate. The moral and social disenfranchisement of users means that they do not have agency to articulate the failings of treatment, and must interpret it as individual failure instead, as shown through Dhiraj and Arbin's stories. The privatization of drug treatment in Nepal locks users in a cycle of treatment which produces harm rather than health but which users cannot question due to the ways in which private centers construct addicts and the placement of centers on governmental and medical peripheries. Private centers provide drug users violence as treatment and blame users when treatment fails them.

The sound of metal fan blades cutting through air, thick with monsoon humidity, filled the silence during a pause in a conversation Dr. Sagun and I were having in his office. With a faraway look on his face, he reflected that:

> An important question could be what is the suicide rate among drug users? Do they know people who have died of suicide? I supervise around 1500 opioid clients in the country, from east to west, I am the focal point for that. I don't have a client that is over 50 years, maybe one or two. So where are they? Have they stopped using drugs? The government thinks so, the rehabilitation centers think so. But no, they have died. They have died because they lacked treatment, they have died from overdoses, they have died because HIV or Hepatitis was never diagnosed or treated.

Behind discussions of government disbursement, treatment mechanisms, and endless flow of Rupees is the cost of lives lost and ruined through stigma, shame, and dehumanization. Both inside and outside of treatment, slow invisible deaths take place, as addicts are unable to break

cycles, unable to access stigmatized treatment, and unable to raise individual voices to stop abuse. The private center lives and breathes within this silence.

Chapter 6. Conclusion

In this piece I have reflected on the causes and consequences of the privatization of substance abuse treatment in urban Nepal. I began with the history of substance abuse and treatment, examining the ways in which the Nepali government has addressed various stages of substance abuse, both as an internal Nepali project, and as a part of the global War on Drugs. I described the multi-source and largely unregulated development of Nepali healthcare, explaining how the incomplete medicalization of addiction, the ceding of medical sovereignty to NGOs, and the privatization of the Nepali medical sector led to a situation in which private entities treated addiction while aligned with a state that maintains a status quo through presence and absence. In this climate, a conjunction of public and private entities exercise biopower.

I then examined this status quo, focusing on the actions of MOHA and the Nepali Police in their treatment of substance abuse as a problem of supply and demand. Through protocols and public statements, the police and MOHA create veneers of progressive human rights, while creating a policy environment in which they cannot enforce these regulations. The location of private centers on the periphery of state and medical regulation allows centers to run as spaces of exception, able to commit illegal practices without breaking the law. The ability to create spaces of exception in urban Nepal is not the result of a unified state, as Agamben has suggested, rather, this process is best theorized by Gupta, who examines the creation of states of exception through a diffuse state, which creates multiple status quos which benefit a minority (Agamben 2005; Gupta 2012). In the case of private substance abuse treatment in Kathmandu, those who benefit from the status quo are members of the police who, despite public statements, profit from referrals and deliveries of patients to select private centers. Private centers and police thus partner in producing docile bodies through forced internment in private centers.

To create themselves as legitimate providers of care to the parents of drug-using sons and daughters, private centers place their role in addiction treatment on the periphery of the Nepali family structure and medical institution. Private centers assume a version of scientific sovereignty, in which medical logics assume state roles in the administration of biopower (Samsky 2012). Private centers are thus privileged to create a new illness in the imagination of the Nepali public. They can accomplish this through massive advertising campaigns which narrate treatment as a linear process of sickness, therapeutics, and recovery. In these narratives, addiction is understood as a curable behavioral defect, meant to be treated in private centers rather than by psychiatrics. This definition allows private centers to sidestep medical regulations while incorporating biomedical vocabularies to naturalize their treatment mechanism as successful. Private centers thus establish authority to treat and intern substance dependent individuals through narrating a specific version of addiction relative to notions of pride and shame, establishing distance from Nepal's burgeoning psychiatric sector, and naturalizing their treatment through the co-option of medical vocabularies.

In their creation of addiction as a behavioral illness, private centers overlay treatment and punishment, justifying giving treatment as violence. The violence I depicted through Sunil, Diraj, and Arbin's narratives describe the ways in which the everyday violence of dehumanization becomes the exceptional violence of torture. This connection demonstrates that private center violence is not a collection of random acts by problematic individuals at select centers, it is a connected process involving the loss of biological and sanitary citizenship. When overlain with incomplete medicalization, which creates space to treat addiction as a moral and behavioral defect, private centers can provide treatment as violence within unregulated spaces of exception. The patient narratives I present depict a series of private center and state failures to uphold

human dignity and provide spaces of healing and safety for its populations marginalized by drug abuse.

Private centers may possess the economic and social capital to form the dominant narrative about addiction, but it is not the only narrative. Collectives of former and current users of drugs attempt to change narratives of behavioral illness. Users are not passive within systems of marginalization, and collectivize in hopes of changing government policy and private center practices. These collectives voice their desire for patientization, taking addiction out of the chaos of behavioral illness into the relative order of Nepali medicine.

Asserting A New Medicine

I slouched into the soft, musty couch on the upper floor of the opioid substitution clinic on a Saturday afternoon. Rain softly padded the ground while Manoj and I drank multiple rounds of steaming milk tea. Karma, the other administrator, had left the office early as many OST center employees did on Saturdays. I had been coming to the center for about 2 months, and after many afternoons such as this one, Manoj and I had exhausted most OST related topics of conversation. These days we usually talked and "practiced Nepali," which, to Manoj seemed to mean 'make fun of Robin's bad Nepali'. I had once caused uproarious laughter when I had forgotten to include a Devanagari symbol in the word "Nepal," instead spelling some variation of "Nipple." While the jokes were almost always at my expense, I cherished the connection I had come to share with all the men who worked in the clinic.

Manoj told me about the day he was diagnosed with Hepatitis C on this somber afternoon. Years ago, his family had found him a lucrative manager's position in Saudi Arabia, a common place of employment for members of the Nepali diaspora. Nepali parents see working in the Middle East as a viable way to get children off drugs, due to gulf countries' harsh

narcotics enforcement policies. His family had arranged everything, but before leaving Manoj had to get a blood test to ensure his good health. After getting his blood drawn at a government hospital earlier that week, Manoj, his father, and his brother made their way back to the hospital to receive the results. Manoj knew that after a decade of intravenous drug use, there was a possibility that he had contracted HIV. The potential of a positive diagnosis and its earth-shattering implications led him to avoid visiting the testing center in the past. When the doctor diagnosed him with Hepatitis C, it confused Manoj and anguished his father and brother, who thought it to be as deadly as HIV. Manoj described how he tried again and again to explain to his family that Hepatitis was not a death sentence, that people lived normal lives with proper management, but this was difficult. It took months for Manoj to normalize his relationship with his family. These days Manoj thinks of himself as incredibly fortunate, he has managed to live a productive life since his diagnosis and now has a wife and son of his own. He finds meaning in his work, tirelessly assisting and advocating for the substance dependent in Kathmandu. Manoj is quick to state that he is unique in his ability to secure treatment for Hepatitis. As an "NGO worker," he able to tap into financial and personal resources that make Hepatitis management possible. Within Nepal's largely privatized healthcare system, care for chronic illness is costly and largely inaccessible to non-elite urban citizens.

According to Manoj, the government "also has the Hepatitis medicine but they are not giving it out. We have to pay for treatment. Other countries are distributing this medicine for free like ARV but if I am not able to pay then I am going to die." Hepatitis care is currently where HIV treatment was in the early 2000's, when it was highly stigmatized and extremely expensive and difficult to treat effectively. A cocktail of INGO intervention, Intravenous Drug User community activism, and governmental restructuring made antiretroviral drugs (ARV), essential

medication for prolonging life after an HIV diagnosis, available to a large portion of the population. Groups of substance-using activists played a major role in pressuring the government to act, unifying in expressions of dissent through the occupation of political space while explicitly stating their identity as drug users. The collectivization of drug users into political groups and the protest activities they involve themselves in allows them to articulate an alternative narrative to private center descriptions of addiction.

Collective Voicing

Collectives of users, represented by groups like Saarathi Nepal, National Users Network Nepal (NUNN), and Recovering Nepal operate as political appendages for addicted and formerly addicted communities. While discrimination limits individuals' ability to change policies and practices within clinics, as collectives, substance users are able to articulate an alternative view of their identity and needs. Arundhati Roy, who has theorized what standing up to the forces of neoliberalism in India might look like, might see user collective's protests as a part of a global reimagining of dissent that represents "a new kind of politics. Not the politics of governance, but the politics of resistance. The politics of opposition. The politics of forcing accountability" (Roy 2002, 150).

Gellner and Karki (2007) describe the history of modern Nepali activism, and define this type of political activity as "the practice of campaigning to influence or re-make the world in line with a consciously articulated programme" (Gellner and Karki 2007, 3). Nepali user collectives fit well into this definition. NUNN is a collective of current and former users which aims "to improve the quality of lives of people who use drugs through empowerment, involvement and advocacy for our health & human rights" (Thapa 2015). As a collective, NUNN works both individually, conducting peer to peer trainings on topics such as HIV and overdose prevention

and on a community level through the organization of protests and social action. NUNN works to re-make the world of the substance dependent in personal and political spaces.

Protest plays a large role in Nepali politics as both a means of asserting a group's agenda, a performance, and a space to further individual political ambitions. In regards to student protest, Amanda Snellinger has asked: "What is the relationship between idealism and opportunism within political activism?" (Snellinger 2018, 3). Protest in Nepal is more complex than simple political voicing, and is often overlain with alternative personal and political agendas. It is beyond the scope of this paper to delve into the complexities of protest and politics in Nepal. Instead I will examine the ways in which user groups use protest as a means of articulating an alternative dialogue regarding substance abuse and treatment.

At the current political moment in Nepal, many groups are involved in articulating alternatives to medical privatization. Dr. Govinda KC, a medical doctor who is also a renowned political activist, perhaps best represents this trend. I encountered protests in the name of Dr. KC's cause on my way to meet with Dr. Sagun on a hot July afternoon. A commotion confronted me at the teaching hospital where we had planned to meet. The entrance area, usually bustling with taxis ferrying the ill from rural parts of Nepal to the city center, was busy with police in full riot gear. They had been called to break up a protest of medical students earlier that day. This protest was related to Dr. Govinda KC's hunger strike to death, in which he attempted to force the government to pass legislation that would formalize the creation of private medical colleges. As I described in the history section, medical education, like drug rehabilitation, is becoming rapidly privatized, as regulatory measures become moot in the face of profitable private industry. Dr. KC was advocating for lowering the cost of government medical schools, and for government provision of medical education to rural areas. Dr. KC fasted 27 days, during which

police forcibly removed him from his home district of Jumla to the teaching hospital where I had planned to meet Dr. Sagun. Because of this forced move, doctors and medical students from across the country instituted a strike, shutting down teaching hospitals all over the country. To break up the protest, police jailed 25 protestors attempting to assist the cause of Dr.KC. The day I encountered the riot police, they had just clashed with groups of medical students attempting to break through a roadblock. After his nearly month-long hunger strike, the government yielded to KC's demands and came back to the negotiating table with the mission of fulfilling their promise of providing "healthcare for all." Protest, in the arena of private medicine, is alive and well in Nepal.

User groups articulate an alternative narrative of addiction to the public through using slogans in protests to express political will and educate the public. Many protests are organized around chanting slogans, some originally Nepali, others co-opted from INGOs involved in the improving of conditions for the substance dependent. These slogans include statements like "Support. Don't Punish" from a global advocacy campaign, and "Human rights, Heath Rights, Harm Reduction" a refrain for the improvement of public health. The slogan which I find best crystallizes the mission of user collectives is borrowed from South African disability activists Michael Masutha and William Rowland, to assert future political viability and a history of disenfranchisement. The slogan: "Nothing About Us Without Us" represents the need for governments to include the voices of the marginalized in policy decisions which radically shape their lives (Charlton 1998).

As actions which occur in public spaces, these protests involve interaction with the public who encounter the articulations of user collectives. Through slogans like those described above, user collectives also disseminate a counter dialogue to private center narratives which depict the

substance dependent as having a behavioral disorder. In this reformation of identity, they can assert themselves as ill individuals rather than immoral people. A representative for NUNN described how protests and education efforts have changed the public perception of the substance dependent, stating that: “Now there is less discrimination, people mostly know that these people have a disease, they are not just criminals. Now there is not so much discrimination in town because people have information that we are not criminals, we don’t deserve to go to jail... It was a program stating we need treatment, addiction is a disease.” Collectivization gives drug users the ability to articulate alternative narratives regarding their treatment.

Reclaiming Identity

In my thesis, I have described histories which have created institutions in which human beings are subject to extreme forms of violence and torture under the guise of behavioral therapy. Governmental and non-governmental structures form narratives which fix interned drug users into cycles which ensure suffering for docile body creation. In examining the counter-narratives presented by user collectives, I attempted to show that this can be otherwise, that individuals can articulate alternatives. This discussion allows us to re-visit the concept of addiction trajectories, a reminder that despite rigid constraints placed on addicted bodies through pseudo-medical and economic structures, individuals cannot be fixed by substances deemed ‘addictive’ or by the structures which demonize them (Garriott and Raikhel 2013).

In contexts of diffuse sovereignty, in which private entities are enabled to exercise state biopower in the creation of docile subjects, what do those who have become projects of bodily normalization demand? While it is difficult to extract an agenda from all users interned at private centers as processes of symbolic violence and marginality affect both constructions of the self and substance users in general, collectives like NUNN articulate an agenda of “patientization.”

Aleksandra Bartoszko has articulated this concept as a user's desire to be included into systems of medical understanding and for state recognition of addiction as an illness (Bartoszko in press). User collectives desire patientization because it simultaneously insists that the government take control of medical treatment and that treatment takes place within these spaces, rather than private centers and prisons. For Nepali user groups, patientization frees addiction from cycles of private clinic-based oppression within which they are ensnared.

The concept of patientization again brings us to the process of medicalization, a trend which numerous scholars have resisted in medical anthropology. Particularly when it is examined in the context of the global north, scholars have linked medicalization to the commodification of illness, the consolidation and corporatization of healthcare, and the co-option and commodification of other sources of healing (Clarke 2009). Some have gone as far as to denounce anthropological engagements with biomedicine that "produce little or no challenge to the perverse economic and power relations that inform and distort every medical encounter in post-industrialized and especially capitalist societies, and with few exceptions" (Scheper-Hughes 1990, 66). Despite medical depictions of biomedical knowledge as unsituated universal truth, the place where biomedical knowledge is situated has drastic effects on its efficacy, and how individuals and communities will internalize it. In the case of Nepali drug rehabilitation, patientization and medicalization disentangles treatment from systems of exploitative economics and dehumanization; OST is, after all, free. Bourgeois has reflected that while the biological effects of drugs may be similar across cultures, the way individuals internalize these experiences and the ways in which governments and societies address and understand users is far from generalizable (Bourgois and Schonberg 2009). This lack of generalizability extends to drug treatment.

With Nepali user groups' desire for patientization in mind, I return to the OST clinic, and the ways in which users could seamlessly move in and out of the clinic and go about their day. While Methadone and Buprenorphine are far from perfect, most of the men I spoke with saw them as a means of restoring normalcy to their lives. In this sense, OST had a feeling that was very non-medical. While patients entered and ingested a globalized pharmaceutical cure, a major part of the good-health practices produced by OST relate to the community formed there, and the ability for users to just go home. As Bartoszko describes about Buprenorphine patients in Norway who desire a different term then patient; for them, "the desire for de-clientisation, de-stigmatisation, and pharmaceutical and social de-othering was as equally significant as becoming 'healthy'" (Bartoszko in press). Thus, when I describe the desire for patientization in rehabilitation treatment in Nepal, I don't advocate for the complete medicalization of rehabilitative treatment. I advocate for the right for ill people to articulate alternative futures and play an active role in their treatment. I argue for the right to imagine an otherwise. "Nothing about us without us."

Works Cited

Abramowitz, Sharon, and Catherine Panter-Brick. 2015. Medical Humanitarianism: Ethnographies of Practice. Pennsylvania: University of Pennsylvania Press.

Adams, Vincanne. 2013. “When People Come First: Critical Studies in Global Health.” In Evidence-Based Global Public Health: Subjects, Profits, Erasures. New Jersey: Princeton University Press.

Adhikari, Ramesh Kant. 2006. “Privatization in Technical Education: The Case of Education of Health Professionals in Nepal.” Regional Health Forum 10 (1): 59–108.

Agamben, Giorgio. 1998. Homo Sacer: Sovereign Power and Bare Life. California: Stanford University Press.

Agamben, Giorgio. 2005. State of Exception. Chicago: University of Chicago Press.

Agar, Michael. 1973. Ripping and Running: A Formal Ethnography of Urban Heroin Addicts. California: Seminar Press.

Alonso, William, and Paul Starr. 1987. The Politics of Numbers. New York: Russell Sage Foundation.

Ambekar, Atul, Ravindra Rao, Anan Pun, Suresh Kumar, and Kunal Kishore. 2013. “The Trajectory of Methadone Maintenance Treatment in Nepal.” International Journal of Drug Policy 24 (6): 57–60.

Asian Network of People who Use Drugs. 2018. “Private Rehab Center Raided and Everyone Rescued.” *ANPUD* (blog), December 10, 2018.

Axelrod, Saul. 1983. Effects of Punishment on Human Behavior. Cambridge: Academic Press.

Bartoszko, Aleksandra. (in press). “Patient Is the New Black. Treatmentality and Resistance toward Patientisation.” Journal of Extreme Anthropology.

Bourdieu, Pierre, and Alain Accardo. 1999. The Weight of the World: Social Suffering in Contemporary Society. Cambridge: Polity Press.

Bourgois, Philippe. 2000. “Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States.” Culture, Medicine and Psychiatry 24 (2): 165–95.

Bourgois, Philippe, and Jeffrey Schonberg. 2009. Righteous Dopefiend. California: University of California Press.

Bowling, Ben. 2011. “Transnational Criminology and the Globalization of Harm Production.” In What Is Criminology?, 359–76. Oxford: Oxford University Press.

Briggs, Charles L. 2003. Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare. California: University of California Press.

Brunson, Jan. 2016. Planning Families in Nepal: Global and Local Projects of Reproduction. New Jersey: Rutgers University Press.

Campbell, Nancy. 2000. Using Women: Gender, Drug Policy, and Social Justice. United Kingdom: Psychology Press.

Campbell, Nancy. 2010. "Toward a Critical Neuroscience of 'Addiction.'" BioSocieties 5 (1): 89–104.

Campbell, Nancy. 2011. "The Metapharmacology of the 'Addicted Brain.' History of the Present 1 (2): 194–218.

Campbell, Nancy. 2012. "Medicalization and Biomedicalization: Does the Diseasing of Addiction Fit the Frame? "In Critical Perspectives on Addiction. Vol. 14. Advances in Medical Sociology. Emerald Group Publishing Limited

Carr, E. Summerson. 2010. Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety. New Jersey: Princeton University Press.

Chakrabarty, Dipesh. 2009. Provincializing Europe: Postcolonial Thought and Historical Difference - New Edition. New Jersey: Princeton University Press.

Charlton, James I. 1998. Nothing about Us Without Us: Disability Oppression and Empowerment. California: University of California Press.

Citrin, David, Agya Mahat, and Hima Bista. 2018. "NGOs, Partnerships, and Public-Private Discontent | Department of Anthropology | University of Washington." Medicine Anthropology Theory 5 (2).

Clarke, Adele. 2009. Biomedicalization: Technoscience, Health, and Illness in the U.S. North Carolina: Duke University Press.

Comaroff, Jean, and John Comaroff. 2004. "Criminal Obsessions, after Foucault: Postcoloniality, Policing, and the Metaphysics of Disorder." Critical Inquiry 30 (4): 800–824.

Conrad, Peter, and Joseph W. Schneider. 2010. Deviance and Medicalization: From Badness to Sickness. Philadelphia: Temple University Press.

Courtwright, David T. 2010. "The NIDA Brain Disease Paradigm: History, Resistance and Spinoffs." BioSocieties 5 (1): 137–47.

Dackis, Charles, and Charles O'Brien. 2005. "Neurobiology of Addiction: Treatment and Public Policy Ramifications." Comments and Opinion. Nature Neuroscience. November 1, 2005.

Das, Veena. 2011. "State, Citizenship, and the Urban Poor: Citizenship Studies: Vol 15, No 3-4." Citizenship Studies 15 (3–4): 319–33.

Das, Veena, and Shalini Randeria. 2015. "Politics of the Urban Poor: Aesthetics, Ethics, Volatility, Precarity: An Introduction to Supplement 11." Current Anthropology 56 (S11): S3–14.

Davis, Angela Y. 2011. Abolition Democracy: Beyond Empire, Prisons, and Torture. New York: Seven Stories Press.

Deleuze, Gilles. 2007. Two Regimes of Madness: Texts and Interviews 1975–1995. Edited by David Lapoujade. Translated by Ames Hodges and Mike Taormina. New York : Semiotext.

Dixit, Hemang. 1999. The Quest for Health: The Health Services of Nepal. Kathmandu: Educational Enterprise Limited

Eriksen, Thomas Hylland, James Laidlaw, Jonathan Mair, Keir Martin, and Soumhya Venkatesan. 2015. "The Concept of Neoliberalism Has Become an Obstacle to the Anthropological Understanding of the Twenty-first Century." Journal of the Royal Anthropological Institute 21 (4): 911–23.

Farmer, Paul. 1996. "On Suffering and Structural Violence: A View from Below." Daedalus 125 (1): 261–83.

Farmer, Paul. 2003. Pathologies of Power: Health, Human Rights, and the New War on the Poor. California: University of California Press.

Farmer, Paul. 2004. "An Anthropology of Structural Violence." Current Anthropology 45 (3): 305–25.

Fassin, Didier. 2007. When Bodies Remember: Experiences and Politics of AIDS in South Africa. California: University of California Press.

Fassin. 2009. "Another Politics of Life Is Possible." Theory, Culture and Society 26 (5): 44–60.

Filc, D. 2004. "The Medical Text: Between Biomedicine and Hegemony." Social Science & Medicine (1982) 59 (6): 1275–85.

Finkler, Kaja. 2004. "Biomedicine Globalized and Localized: Western Medical Practices in an Outpatient Clinic of a Mexican Hospital." Social Science & Medicine, Hospital Ethnography, 59 (10): 2037–51.

Foucault, Michel. 1982. “The Subject and Power.” Critical Inquiry 8 (4): 777–95.

Foucault, Michel. 1994. The Birth of the Clinic: An Archaeology of Medical Perception. New York: Vintage.

Foucault, Michel. 1995. Discipline and Punish: The Birth of the Prison. New York: Knopf Doubleday Publishing Group.

Galtung, Johan. 1969. “Violence, Peace, and Peace Research.” Journal of Peace Research 6 (3): 167–91.

Ganti, Tejaswini. 2014. “Neoliberalism.” Annual Review of Anthropology 43 (1): 89–104.

Garcia, Angela. 2010. The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande. California: University of California Press.

Garriott, William, and Eugene Raikhel. 2015. “Addiction in the Making.” Annual Review of Anthropology 44 (1): 477–91.

Gellner, David N. “Caste, Ethnicity and Inequality in Nepal.” Economic and Political Weekly 42, no. 20 (2007): 1823–28.

Gellner, David N, and Mrigendra Bdr Karki. 2007. “The Sociology of Activism in Nepal: Some Preliminary Considerations,” In Social Dynamics in Northern South Asia: Political and Social Transformations in North India and Nepal, 361-397 New Delhi: Manohar Publishing

German Health Practice Collection. 2015. “Opioid Substitution Therapy in Nepal.” Deutsche Gesellschaft fur Interationale Zusammenarbeit.

Ghimire, Bhagabati, S. Pilar Suguimoto, Saman Zamani, Masako Ono-Kihara, and Masahiro Kihara. 2013. “Vulnerability to HIV Infection among Female Drug Users in Kathmandu Valley, Nepal: A Cross-Sectional Study.” BMC Public Health 13 (1)

Gilson, L., P. D. Sen, S. Mohammed, and P. Mujinja. 1994. “The Potential of Health Sector Non-Governmental Organizations: Policy Options.” Health Policy and Planning 9 (1): 14–24.

Good, Mary-Jo DelVecchio. 2001. “The Biotechnical Embrace.” Culture, Medicine and Psychiatry 25 (4): 395–410.

Gostin, Lawrence O. 2008. “‘Old’ and ‘New’ Institutions for Persons with Mental Illness: Treatment, Punishment or Preventive Confinement?” Public Health 122 (9): 906–13.

Gupta, Akhil. 2012. Red Tape: Bureaucracy, Structural Violence, and Poverty in India. North Carolina: Duke University Press.

Gurung, Om. 2009. "Social Inclusion: Policies and Practices in Nepal." Occasional Papers in Sociology and Anthropology 11: 1–15.

Halleck, Seymour L. 1971. Psychiatry and the Dilemmas of Crime: A Study of Causes, Punishment, and Treatment. California: University of California Press.

Hansen, Helena, and Samuel K. Roberts. 2012. "Two Tiers of Biomedicalization: Methadone Buprenorphine and the Racial Politics of Addiction Treatment." Critical Perspectives on Addiction, 79–102.

Hansen, Thomas Blom, and Finn Stepputat. 2009. Sovereign Bodies: Citizens, Migrants, and States in the Postcolonial World. New Jersey: Princeton University Press.

Harper, Ian. 2014. Development and Public Health in the Himalaya: Reflections on Healing in Contemporary Nepal. 1 edition. London ; New York, NY: Routledge.

Harper, Ian, Nabin Rawal, and Madhu Subedi. 2011. "Disputing Distribution: Ethics and Pharmaceutical Regulation in Nepal." Studies in Nepali History and Society 16 (1): 1–39.

Harris, Shana. 2015. "To Be Free and Normal: Addiction, Governance, and the Therapeutics of Buprenorphine." Medical Anthropology Quarterly 29 (4): 512–30.

Hasegawa, Kohei, Janice A. Espinola, David F. M. Brown, and Carlos A. Camargo. 2014. "Trends in U.S. Emergency Department Visits for Opioid Overdose, 1993-2010." Pain Medicine (Malden, Mass.) 15 (10): 1765–70.

Heath, Dwight B. 1958. "Drinking Patterns of the Bolivian Camba." Quarterly Journal of Studies on Alcohol 19 (3): 491–508.

Heath, Dwight B. 1987. "Decade of Development in the Anthropological Study of Alcohol." In Constructive Drinking, 16–69. Routledge.

Heelas, Paul. 1983. "Anthropological Perspectives on Violence: Universals and Particulars." Zygon 18 (4): 375–404.

Herman, Judith L. 2015. Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror. New York: Basic Books.

Holden, Chris. 2005. "Privatization and Trade in Health Services: A Review of the Evidence." International Journal of Health Services 35 (4): 675–89.

Ismail, Feyzi. 2017 "Polar Opposites? NGOs, Left Parties and the Fight for Social Change in Nepal." Critical Sociology 44, no. 4–5

Jha, Chandra Kant, and David Plummer. 2014. "Culture, Identity and the Embodiment of Illicit Drug Use in Nepal." Mental Health and Substance Use 7 (1): 5–18.

Justice, Judith. 1989. Policies, Plans, and People: Foreign Aid and Health Development. California: University of California Press.

Karkazis, Katrina. 2008. Fixing Sex: Intersex, Medical Authority, and Lived Experience. 1 edition. Durham: Duke University Press Books.

Keane, Helen. 2009. "Foucault on Methadone: Beyond Biopower." International Journal of Drug Policy 20 (5): 450–452

Keaney, Michael. 2002. "Unhealthy Accumulation: The Globalization of Health Care Privatization." Review of Social Economy 60 (3): 331–57.

Keraghel, Chloe. 2001. "Nepal: A Quick Response." Peddro: Drug Abuse and AIDS, 61–62.

Kleinman, Arthur. 1988. Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books

Kolodny, Andrew, David T. Courtwright, Catherine S. Hwang, Peter Kreiner, John L. Eadie, Thomas W. Clark, and G. Caleb Alexander. 2015. "The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction." Annual Review of Public Health 36 (1): 559–74.

Kothari, Manu L, and Lopa A Mehta. 1988. "Violence in Modern Medicine." Science, Hegemony, and Violence.

Krohn-Hansen, Christian. 1994. "The Anthropology of Violent Interaction." Journal of Anthropological Research 50 (4): 367–81.

Kymlicka, Will. 2001. Politics in the Vernacular: Nationalism, Multiculturalism, and Citizenship. United Kingdom: Oxford University Press.

Labonte, Ronald. 1998. "Healthy Public Policy and the World Trade Organization: A Proposal for an International Health Presence in Future World Trade/Investment Talks." Health Promotion International 13, no.3: 245–56.

Leshner, A. I. 1997. "Addiction Is a Brain Disease, and It Matters." Science (New York, N.Y.) 278 (5335): 45–47.

Liechty, Mark. 2003. Suitably Modern: Making Middle-Class Culture in a New Consumer Society. New Jersey: Princeton University Press.

Liechty, Mark. 2017. Far Out: Countercultural Seekers and the Tourist Encounter in Nepal. Chicago: University of Chicago Press.

Lock, Margaret. 2003. “Globalization and Cultures of Biomedicine: Japan and North America.” In Medicine Across Cultures, 155–73. New York: Springer.

Mattingly, Cheryl. 1998. Healing Dramas and Clinical Plots: The Narrative Structure of Experience. United Kingdom: Cambridge University Press.

Mattingly, Cheryl, and Linda C. Garro. 2000. Narrative and the Cultural Construction of Illness and Healing. California: University of California Press.

Maturo, Antonio. 2012. “Medicalization: Current Concept and Future Directions in a Bionic Society.” Mens Sana Monographs 10 (1): 122–33.

McGregor, Sue. 2001 “Neoliberalism and Health Care.” International Journal of Consumer Studies 25, no.2: 82–89.

McHugh, Ernestine. 1998. “Situating Persons: Honor and Identity in Nepal.” In Selves in Time and Place: Identities, Experience, and History in Nepal, 155–74. Maryland: Rowman & Littlefield.

Mendoza, Sonia, Allyssa Stephanie Rivera, and Helena Bjerring Hansen. n.d. “Re-Racialization of Addiction and the Redistribution of Blame in the White Opioid Epidemic.” Medical Anthropology Quarterly.

Mertus, Julie, and Kristin Rawls. 2008. “Crossing the Line: Insights from Foucault on the United States and Torture.” In Discipline and Punishment in Global Politics: Illusions of Control, edited by Janie Leatherman, 27–40. New York: Palgrave Macmillan

Meyers, Todd. 2013. The Clinic and Elsewhere: Addiction, Adolescents, and the Afterlife of Therapy. Washington: University of Washington Press.

Mishra, Shiva Raj, and Pawan Acharya. 2013. “What Is Fueling Privatization in Health Care in Nepal?” Health for All 1 (1): 7–11.

Netherland, Julie, and Helena Hansen. 2017. “White Opioids: Pharmaceutical Race and the War on Drugs That Wasn’t.” BioSocieties 12 (2): 217–38.

NIDA. 2015. “Nationwide Trends” Retrieved from: https://www.drugabuse.gov/publications/drugfacts/nationwide-trends on 2019, March 9

Novas, Carlos. 2006. “The Political Economy of Hope: Patients’ Organizations, Science and Biovalue.” BioSocieties 1 (3): 289–305.

Ojha, Saroj Prasad, Suraj Sigdel, Hans-Günter Meyer-Thompson, Harald Oechsler, and Uwe Verthein. 2014. "'South Asian Cocktail'--the Concurrent Use of Opioids, Benzodiazepines and Antihistamines among Injecting Drug Users in Nepal and Associations with HIV Risk Behaviour." Harm Reduction Journal

O'Malley, Pat, and Mariana Valverde. 2004. "Pleasure, Freedom and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption." Sociology 38 (1): 25–42.

Pettit, Becky, and Bruce Western. 2004. "Mass Imprisonment and the Life Course: Race and Class Inequality in U.S. Incarceration." American Sociological Review 69 (2): 151–69.

Preble, Edward, and John J. Casey. 1969. "Taking Care of Business—The Heroin User's Life on the Street." International Journal of the Addictions 4 (1): 1–24.

Raikhel, Eugene, and William Garriott, eds. 2013. Addiction Trajectories. Durham and London: Duke University Press Books.

Rapp, Rayna. 2000. Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America. 1st ed. New York: Routledge.

Reid, Genevieve, and Gary Costigan. 2001. "Revisiting 'The Hidden Epidemic': A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS." A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS. Australia: The Centre for Harm Reduction, The Burnet Institute.

Riches, David. 1986. The Anthropology of Violence. Oxford, UK ; New York: Blackwell.\

Room, Robin, and Peter Reuter. 2012. "How Well Do International Drug Conventions Protect Public Health?" The Lancet 379 (9810): 84–91.

Rose, Nikolas. 2007. The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century. New Jersey: Princeton University Press.

Rose, Nikolas, and Carlos Novas. 2004. "Biological Citizenship." In Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems, 1st ed., 439–63. New Jersey: Wiley-Blackwell.

Roy, Arundhati. 2002. The Algebra of Infinite Justice. New Delhi: Penguin Books India.

Sackett, D. L., W. M. Rosenberg, J. A. Gray, R. B. Haynes, and W. S. Richardson. 1996. "Evidence Based Medicine: What It Is and What It Isn't." BMJ (Clinical Research Ed.) 312 (7023): 71–72.

Samsky, Ari. 2012. "Scientific Sovereignty: How International Drug Donation Programs Reshape Health, Disease, and the State." Cultural Anthropology 27 (2): 310–32.

Scheper-Hughes, Nancy. 1990. "Three Propositions for a Critically Applied Medical Anthropology." Social Science & Medicine, Special Issue Critical Medical Anthropology: Theory and Research, 30 (2): 189–97.

Scheper-Hughes, Nancy, and Philippe Bourgois. 2004. Violence in War and Peace: An Anthology. New Jersey: Wiley.

Shah, Saubhagya. 2002. "From Evil State to Civil Society." In State of Nepal, 137–160. Lalitpur: Himal Books.

Shankar, P. Ravi. 2011. "Privatization Of Medical Education In Nepal And South Asia: An Important Area For Future Research," Medical Education 2 (11)

Shapiro, Johanna. 2018. "'Violence' in Medicine: Necessary and Unnecessary, Intentional and Unintentional." Philosophy, Ethics, and Humanities in Medicine 13 (1): 7.

Shrestha, Nirakar Man. 1992. "Alcohol and Drug Abuse in Nepal." British Journal of Addiction 87 (9): 1241–1248.

Singer, Merrill. 2007. Drugging the Poor: Legal and Illegal Drugs and Social Inequality. Long Grove: Waveland Press Inc.

Singer, Merrill. 2012. "Anthropology and Addiction: An Historical Review." Addiction 107 (10): 1747–55

Single, E. 1995. "Defining Harm Reduction." Drug and Alcohol Review 14 (3): 287–90.

Sinhas, Ashish. 2008. "Exploring the Social Dimensions of Drug Abuse and Service Interventions in Nepal." Studies in Nepali History and Society 13 (1): 71–115.

Snellinger, Amanda Therese. 2018. *Making New Nepal: From Student Activism to Mainstream Politics*. Seattle: University of Washington Press.

Spicer, P. 1997. "Toward a (Dys)Functional Anthropology of Drinking: Ambivalence and the American Indian Experience with Alcohol." Medical Anthropology Quarterly 11 (3): 306–23.

Street, Alice. 2014. Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital. North Carolina: Duke University Press.

Subedi, Madhusudan. 2010. "Caste System: Theories and Practices in Nepal." Himalayan Journal of Sociology and Anthropology 4: 134–59.

Szasz, Thomas. 2007. Medicalization of Everyday Life: Selected Essays. New York: Syracuse University Press.

Thapa, Ashwin. 2015. "National Users Network of Nepal (NUNN) Community-led network of people who use drugs in Nepal." NUNN.

United Nations Office on Drugs and Labor. 2018. "World Drug Report 2018." United Nations.

UNODC. 2019. "Nepal: Discussing Drug Abuse in Schools - Youth Centric Programmes Help in Creating Awareness." 2019. https://www.unodc.org/southasia/frontpage/2013/July/nepal-discussing-drug-abuse-in-schools.html.

Urla, Jacqueline. 1993. "Cultural Politics in an Age of Statistics: Numbers, Nations, and the Making of Basque Identity." American Ethnologist 20 (4): 818–43.

Valverde, Mariana. 1998. Diseases of the Will: Alcohol and the Dilemmas of Freedom. United Kingdom: Cambridge University Press.

Vrecko, Scott. 2006. "Folk Neurology and the Remaking of Identity." Molecular Interventions 6 (6): 300.

Vrecko, Scott. 2010. "Birth of a Brain Disease: Science, the State and Addiction Neuropolitics." History of the Human Sciences 23 (4): 52–67.

WHO. 2010a. "Information Sheet on Opioid Overdose." WHO. http://www.who.int/substance_abuse/information-sheet/en/.

WHO. 2010b. "Report on People Who Inject Drugs in the South-East Asia Region." 2010. New Delhi, India: World Health Organization, Regional Office for South-East Asia.

WHO 2012 "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence." 2010. World Health Organization https://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

UNODC/WHO. Nd. "Global Initiative on Primary Prevention of Substance Abuse." n.d. WHO. Accessed February 7, 2019. https://www.who.int/substance_abuse/activities/global_initiative/en/.

Wilton, Robert, and Christopher M. Moreno. 2012. "Critical Geographies of Drugs and Alcohol." Social & Cultural Geography 13 (2): 99–108.

Wodak, A., S. Sarkar, and F. Mesquita. 2004. "The Globalization of Drug Injecting*." Addiction 99 (7): 799–801

Young, Iris Marion. 1994. "Punishment, Treatment, Empowerment: Three Approaches to Policy for Pregnant Addicts." Feminist Studies: FS 20 (1): 33–57.