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David M. Citrin

The Anatomy of Ephemeral Care:  
Health, Hunger, and Short-Term Humanitarian Intervention in Northwest Nepal

David M. Citrin

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Reading Committee:

Rachel Chapman, Chair

Stephen Bezruchka

James Pfeiffer

Program Authorized to Offer Degree:  
Department of Anthropology

University of Washington

**Abstract**

The Anatomy of Ephemeral Care:  
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David M. Citrin

Chair of the Supervisory Committee:

Rachel Chapman  
Associate Professor, Department of Anthropology  
Adjunct Associate Professor, Department of Global Health

Drawing upon two and a half years of ethnographic fieldwork conducted between 2006 through 2010, this dissertation explores the experiences, traces and (after)lives of three prominent models of short-term care—medical volunteer stints, what I call “medical voluntourism”; “health camps”; and intermittent food aid distribution programs—as they play out in the complex domain of everyday politics and unmet basic needs in Nepal’s remote mountainous district of Humla.

To shed light on these phenomena, I ground this ethnography in the stories and lived experiences of Humli people seeking an end to sickness and hunger, and attending to other basic needs, amidst the fleeting forms of care that have appeared around the claims and representations of poverty and suffering made on their behalf. I map the social and political lives of medicines and food aid distributed at these ephemeral events by exploring how and why people and “aid commodities” move in and between sites of intervention and situations of need. I also examine the circulations of foreign medical volunteer programs in Humla to show how volunteers have their own social and material effects and afterlives. I look at the everyday ways that Humli people navigate these interventions in settings of chronic scarcity using creative strategies to

meet their healing and eating needs, and how in turn these interventions inform local perceptions of needs, places, and possibilities. In doing so, I illuminate the paradoxical roles that these fleeting forms of care can play in both supporting and/or endangering health care delivery and humanitarian efforts to address hunger in war-torn and post-conflict environments, and how short-term forms of care run largely by foreign actors and institutions often comprise a powerful nongovernmental government that shapes and constrains local aspirations and hopes for improved livelihoods. To this end, I advance three central arguments.

First, I propose that the presence and practices of short-term medical volunteers in Humla contribute to reconfiguring local ideas about health, medicine, and wellbeing. Second, I propose that the medicines and food aid obtained at health camps and food aid programs—which, in this dissertation, I refer to as aid commodities—come to have meaning, value, and uses that both relate to and extend beyond those immediately associated with medical treatment and food shortages during times of war and post-conflict. Third, I propose that while health camps and food aid programs fill a need here and there, they obscure the historical and structural reasons why Humli people experience sickness and hunger, and ultimately that these interventions contribute to the medicalization of unmet basic needs by partitioning out through discrete interventions the inextricable experiences and pursuits of health, hunger, and wellbeing.

Exploring why Nepali people seek out medical volunteers, and attend or do not attend health camps and food aid programs forces us to expand our understanding of the landscapes in which people seek relief from sickness, hunger, and suffering. It also challenges us to broaden our conceptualization of the lived experience of health, hunger, and wellbeing while also critically examining and weighing the possibilities and limits of ‘doing good’ through prevailing short-term models of care.

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## LIST OF ACRONYMS & ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
CDO	Chief District Officer
DHO	District Health Office(r)
FCHV	Female Community Health Volunteer
GHW	Government Health Worker
HA	Health Assistant
HCW	Health Care Worker
HMGoN	His Majesties Government of Nepal
NGO	Nongovernmental Organization
MoHP	Ministry of Health and Population
MV	Medical Volunteer
NHRC	Nepal Health and Research Council
NC	Nepali Congress Party
NMC	Nepal Medical Council
NPR(s)	Nepali Rupee(s)
PHC	Primary Health Care
RHO	Regional Health Office(r)
SWC	Social Welfare Council
SBA	Skilled Birth Attendant
UML	United Marxist Leninist Party
UNFPA	UN Fund for Population Assistance
WFP	United Nations World Food Programme
USAID	U.S. Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

## Note on Nepali Transliteration and Dates

In this dissertation, I have transliterated Nepali words in Roman type, though in some places I have retained the Devanagari script. In transliterations, I have tried to differentiate between retroflex and dental, and aspirated and non-aspirated consonants—perhaps to keep my own language skills in tact more than anything else. I apologize to non-Nepali speakers if this is more confusing than helpful. For example, “द” is written as (*d*), (*dh*) for “ध”, (*D*) for “ड” and (*Dh*) for “ढ”. For the letter “छ” I have indicated aspiration using (*chh*) and for “च” (*ch*). To indicate the long vowel “aa” as in “father,” I use the diacritic (*ā*). Nasalized vowels in Roman type are often denoted with a tilde (~) over the vowel, such as in “*yahã*,” the Nepali word for “here.” However, in this dissertation, I have indicated nasalized vowels by using (*āN*). I refer interested readers to Watters and Rajbhandary (2006: 22-41) and Shapiro (1989: 8-23) for a complete discussion of the Devanagari syllabary and pronunciation.

\*

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\*

I provide dates mostly using the Gregorian calendar, however in several places I use the Nepali style, *Vikram Samvat* (v.s.), or era, which began in 57 BC. So, for example, 2057 v.s. corresponds to the Gregorian year 2000. I also use Nepali and Gregorian months; the approximate dates correspond as follows:

### Nepali Month (v.s.)

### Gregorian Month

*Baisākh*

April / May

*Jeth*

May / June

*Asār*

June / July

*Swarān*

July / August

*Bhadau*

August / September

*Asoj*

September / October

*Kārtik*

October / November

*Māngsir*

November / December

*Paus*

December / January

*Māgh*

January / February

*Fālgun*

February / March

*Chait*

March / April

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## **DEDICATION**

For my mother, Karen Citrin.  
I love you, and I miss you.

## CHAPTER ONE: INTRODUCTION

### **The Anatomy of Ephemeral Care: Health, Hunger, and Short-Term Intervention in Northwest Nepal**

*My grandson will be born with sleeping pills in his eyes,  
his potency already dead, needing no vasectomy.*

~ Banira Giri, “*Samay timi sadaiNko vijetā*” (Time you are always the winner), 1991

*It is likely that somebody will try and use Karnali’s poverty and hunger in the international market as a begging bowl. That is why it is important for the people of Karnali to be well informed of what is being done to their land, and also be aware of its glorious history.*

~ Tsewang Lama, *Kailash Mandala*

*Foreigner organizations [bideshi sansthā] come to help because here we are poor...we have nothing here, look around...But, I think that if there were no organizations it would be better, because up until now they have not brought development [bikās]...Helicopters come and the big people [Thulo mānchhe] on the committees of the organizations in the district headquarters eat the money, they eat the majority of the cow, and the fine stream of milk flowing out of the teats, we are all left to fight for this. Is there hope in this? [Yesmā āshā kahāN hunchha?]*

~ Bajjir Bishwa Karma, farmer, southern Humla

### **Framing the Landscape of Short-Term Care in Nepal**

Nepal has long been represented as a “closed” land until the policy of strictly controlling its borders was officially loosened in 1951. One of the world’s most famous travelers, Marco Polo, is said to have described Nepal as a ‘wild and mountainous country little frequented by strangers.’ Some of the other phrases used to describe Nepal include, “The Last Stronghold,” “The Last House of Mystery,” “The Sequestered-”, “Little Known-“, and “Hermit Kingdom of Nepal,” which is supposed to be “More Hidden than Mecca.” The idea of Nepal as “closed” to the world “containing populations representing primitive and ancient civilizations, ancient customs and ancient methods of life, unaffected by contact with what is known as the civilized world” (Northey 1937: 2) has been a constant trope that has shaped how Nepal is represented in

English (Harper 2007). Consequently, and somewhat paradoxically, it has been considered both an untouched Shangri-La and a forgotten, impoverished country in desperate need of ‘catching up.’ As Harper (2007: 3) fittingly notes, following Nepal’s putative “opening,”

A huge amount of wish fulfillment seemed to have been poured into this space as explorers, travelers, scientists, anthropologists, missionaries, developers from a Euro-American elsewhere were exposed to the secrets of the closed land for the first time and Nepal was “worlded.”

One effect of this worlding was to usher in 60 years of development, or *bikās*, which quickly became the rallying cry of an emerging Nepali state<sup>1</sup> and a rapidly growing number of nations and international organizations that rushed to Nepal. In addition to the professed need for healing that followed along with the coming of missionaries, Nepal was seen as being in need of other forms of modernization. Nepal’s strategic geopolitical location between China and India, its political neutrality and stability at the time, its relative poverty, and its astounding beauty made it an important and ideal focus for these healing and developing missions, each with their own set of prescriptions (Harper 2003; Justice 1978: 9). Over time the number of nations involved in providing aid and coordinating development programs in Nepal steadily grew, and a sense of the exponential growth of nongovernmental organizations (NGOs) working in Nepal can be glimpsed in numbers. In the late 1970s there were only a few dozen, in 1990 there were approximately 200 registered in the country, and current estimates hover near 50,000 (Dhakal 2010; Khanal 2006; Shah 2008; Social Welfare Council 2009).

Initially, large-scale development programs focused on improving infrastructure, medical services, and education in the capital—Kathmandu—and its surrounding areas; and outside the capital in rural areas, where the majority of Nepali people live, programs focused primarily on agricultural development. The United States and other external donors and nations with allied geopolitical interests in the region following WWII were the principal funders of these projects. The famous slogan of Mao Zedong’s protracted agrarian revolution, “land to the tiller,” was of interest to the emerging Communist parties in Nepal, as well as to those nations vested in squelching the radical sentiment through which Communism was spreading in the region.

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<sup>1</sup> Prithvi Narayan Shah from Gorkha formed Nepal as a state in 1768 following his brutal conquest of all its territories and the Kathmandu Valley. However, as Pigg (1992: 496) notes, the model of a nation-state as “a sovereign, politically demarcated territory inhabited by a culturally unique people” does not accurately fit a land of some 90 plus ethnic groups forcibly unified and squeezed into a caste-system that was adopted from India.

However, smaller scale “community-led” and rural development interventions meant to achieve this goal were subject to ‘elite capture’<sup>2</sup> or had the unintended consequences of restricting the land and agro-pastoral practices that provided community livelihoods. In these ways, development projects moved resources and programs—and all the attendant connections to emerging social, educational, and political economic spheres—to some areas and groups of people while neglecting others. This resulted in new kinds of disparities in entitlements to food, health status, and overall wellbeing and hope for improved life chances across and within regions.

The failure of successive governments and an exploding number of NGOs to address the uneven distribution of development contributed to a heightened sense of marginality for communities living in Nepal’s remote districts, whose histories were already those of ethnic marginalization, institutionalized neglect, and increasing unmet basic need—which I discuss in detail in chapter two. This in part spurred the Communist Party of Nepal–Maoist (CPN–M) to drop out of mainstream politics, go underground, and began a decade-long, armed “People’s War” (Nepali: *Janā Yuddha*) against the state in 1996. The paradoxes of the struggle quickly became clear, as communities throughout the country became caught in the middle of the idealism of revolution and the brutality of fighting. Violence and excesses by state and rebel security forces caused widespread distrust and resentment towards all those who “fought” or “defended” in the name of the people. A conservatively estimated 13,000 deaths were attributed to the ten-years of fighting; conservative because the indirect costs of insurgency and counter-insurgency are the instances of human rights abuses, hunger, and illnesses that claim up to thirty times as many lives as direct combat (Human Security Report 2005).

During and in the wake of the ten-year conflict, development programs, humanitarian relief efforts, and post-conflict projects began to overlap, particularly in remote regions of Nepal. In this process, short-term models of intervention such as medical volunteer stints, so-called “health camps,” and food aid programs became more ubiquitous than long-term development projects. In part, the popularity of these transient programs is circumscribed by the formidable task of addressing the underlying conditions of sickness and hunger in a largely rural Nepal, which are ultimately rooted in conditions of poverty. These models have also had the overall

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<sup>2</sup> This generally refers to the practice by local elites with economic, social, political or other forms of power taking control of resources meant for a larger group.

effect of crystalizing the notion of poverty as defined in terms of food scarcity and an absence of health care. More and more, branches of the Nepali government, security forces, and a growing number of foreign medical volunteers working with NGOs in Nepal and seeking to “do good” or gain global health (care) experience fly in to remote areas, stay for a few hours or days to conduct surgeries and distribute medicine, and then leave again. Similarly, NGO- and state-run food aid programs arrive unpredictably in mountainous districts to distribute subsidized rice grains to populations who often walk great distances to stand and wait in long lines to purchase it. These short-term interventions land in places of chronic scarcity and need, professing concern for populations through programmatic role-out, but do not stay to see if needs are met, invariably missing the social and material effects of their ‘transient presence.’ In this dissertation, I refer to these short-term models of intervention as “ephemeral forms of care.”

As these increasingly globalized models of intervention become a more frequent presence in Nepal’s neoliberal development and aid sectors, they also seem to reshape—at times even to generate—the very conditions of privation and crisis that seem to necessitate their perpetuation. There is a growing need to understand the ongoing and potentially unforeseen implications of episodic development and humanitarian interventions amidst landscapes hit by “unnatural disasters” with historical roots. This is to ask, what might be some of the long-term impacts of short-term models of care? To begin to move towards answering this question, I focus this dissertation on the historical and current social, political, and economic conditions that give rise to emergent forms of short-term care in remote Nepal, and the experiences, traces, and (after)lives of these interventions during and after periods of war.

## **Research Questions and Objectives**

My research sought to answer four interrelated questions about three prominent forms of short-term care: medical volunteer programs, health camps, and food aid.

- 1) How do participants, especially Nepali attendees, experience these short-term models of care, both during and after these events and people have come and gone?

- 2) How do short-term medical volunteer programs, health camps, and food aid programs shape experiences of health and healing, and hunger and eating in Humla? And, how are Humli people interacting with these fleeting forms of care to meet other needs?
- 3) How do short-term models of care shape Humli ideas of local worlds and imagined worlds elsewhere?
- 4) Beyond the borders of Humla and Nepal, what can these short-term models tell us more broadly about the nature of ‘state power’ as the state is reconstituted, and understood as, an emergent nongovernmental government that consolidates access to and control over the basic material and non-material resources that promote and sustain health and wellbeing?

At its heart, this is a dissertation about health, hunger, and hope. Framed as a case study, this dissertation draws upon two and a half years of ethnographic fieldwork conducted between 2006 and 2010 in Nepal’s far northwest Karnali Zone district of Humla. I focus specifically on the occurrence of (1) short-term medical volunteer programs, (2) health camps, and (3) food aid distribution events as they play out in the complex domain of everyday politics and unmet basic needs in remote Nepal. This dissertation explores the “anatomy” of these ephemeral models of care through a detailed examination of their structure, relations, and inner workings. To shed light on these phenomena, I ground this discussion in the stories and lived experiences of Humli<sup>3</sup> people seeking an end to sickness and hunger, and attending to other basic needs, amidst the interventions that have appeared around the claims and representations of poverty and suffering made on their behalf.

In this dissertation, I show how intermittent humanitarian and development models inevitably (re)shape local politics of healing and eating in Humla in vital ways. I map the social and political lives of medicines and food aid distributed at these ephemeral events by exploring how and why people and “aid commodities” move in and between sites of intervention and situations of need. I also examine foreign medical volunteer programs in Humla to show how the

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<sup>3</sup> Rauber (1980: 60) writes that “Humli” is the Tibetan genitive that coincides with the Nepali adjective of Humla, though I use it to refer to all those who call the district of Humla their home.

volunteers, themselves, move as a kind of aid commodity with their own social and political effects and afterlives. I focus on how Humli people navigate these interventions using creative strategies to meet their healing and eating needs, and how in turn these interventions inform local perceptions of needs and places. In doing so, I illuminate the paradoxical roles that these fleeting forms of care can play in both supporting and/or endangering health care delivery and humanitarian efforts to address hunger in war-torn and post-conflict environments, and how short-term forms of care also inform local aspirations and hope for improved livelihoods.

I aim to expose the roots and costs of these ephemeral practices, which have agents and targets and empower certain agendas and political power accumulation over others. I show how shifting forms of short-term intervention perpetuated by a growing “nongovernmental government” (Ferguson and Gupta 2002) aggravate already fragile conditions and potentially deepen hunger and suffering on several levels; however, people respond with creative resilience that is, in turn, shaped by shifting centers of power that are no longer well understood as the nation state.

To this end, I advance three related arguments.

First, I propose that while foreign medical volunteers who participate in short-term health care programs in Humla go to ‘do good,’ their presence and practices contribute to reconfiguring local ideas about medicine, health, and health care, while simultaneously reinforcing social and economic inequalities. Second, I propose that the medicines and food aid obtained at health camps and food aid programs—which, in this dissertation, I refer to as aid commodities—come to have meaning, value, and uses that both relate to and extend beyond health and hunger during times of war and post-conflict. Third, I propose that while short-term medical and food aid programs fill a need here and there, they (i) obscure the historical and structural reasons why people in this region experience sickness and hunger, and (ii) ultimately contribute to the medicalization of unmet basic needs by partitioning out through discrete interventions the inextricable experiences and pursuits of health, hunger, and wellbeing.

Exploring why Nepali people seek out medical volunteers, and attend or do not attend health camps and food aid programs, forces us to expand our understanding of the landscapes in which people seeking relief from sickness and hunger may find the range of available options more or less acceptable (Chapman 2010: 32). It also challenges us to broaden our conceptualization of the lived experience of health, hunger, and wellbeing while also critically

examining and weighing the possibilities and limits of ‘doing good’ through prevailing short-term models of care.

### **Towards an Ethnography of Ephemeral Events**

In 2004, with no medical or public health training of any kind, I went to Nepal’s far northwest Karnali district of Humla on my first “medical voluntourism” trip. I was volunteering with a group of NGOs conducting what was being called “the mother of all health camps,” which had the stated goal of registering and treating as many of the local population as possible. Broadly defined, “health camps” (*swāsthya shivir*, as they are known throughout Nepal) are stationary or mobile short-term medical clinics set up for target communities, generally lasting anywhere from a day to a week (Adams 1998: 189). There are many different kinds and combinations of camps, such as general health camps, dental and eye camps, reproductive health and family planning camps, uterine prolapse and fistula camps, specialized surgical camps, orthopedic camps, speech therapy camps, and even acupuncture and massage therapy camps. Equally vast are the assemblages of global institutions and groups (Ong and Collier 2005) that organize and sponsor them. These include NGOs—which have exploded in number throughout Nepal—other development and aid groups, international medical volunteer programs, private hospitals, and branches of Nepal’s Ministry of Health and Population (MoHP). During and in the wake of the People’s War, both Maoist and government security forces also conducted health camps, drawing Nepal’s already fractured health care efforts into the battlefield, and politicizing the movement and meanings of medicine and other aid commodities in rural areas.

The nine-day general health camp I attended brought together volunteer physicians, nurses, surgeons, lab technicians, and medical students from Nepal, India, Austria, Germany, Canada, the United States and the United Kingdom to establish a free medical clinic and provide services and consultations to roughly 6000 people, many having walked for days across the expanse of a vast and road-less mountain district. As is often the case, a list of the medical services made available at the free health camp were advertised in advance in English and Nepali on radio and television, in newspapers, and with sheet-sized banners and posted flyers hung throughout the district. The services included:

- Health screening, investigation & general test – diabetes, TB, etc.
- Pre & post-operative care & patient counseling
- General surgery
- Internal medicine
- Gynecology, maternity & family planning services
- Pediatrics
- Dental component
- Eye camp component
- Orthopedics
- Ear, nose & throat (ENT) & skin
- STDs and communicable diseases
- Diagnostic services: x-ray, ultrasound, ECG, etc.
- Lab services, including basic investigative facilities (Liver function test, Tuberculosis, blood, sugar, culture/lipid test, gastrointestinal)
- Vaccinations: possibly – MMR (Measles, Mumps, Rubella) and/or Tetanus, Hepatitis, Polio
- Controlled and proper distributions of medicines
- Post-camp follow-up – patient care, monitoring, and final reporting

At the time, the People’s War swelled fiercely throughout the country, and most NGOs had stopped work in Humla—either voluntarily or at the armed appeal of the Maoists. In remote areas, an influx of medical supplies—often thousands of dollars’ worth—means a great deal, and I suspect that the direct input of camp medicines was a primary reason that the Maoists allowed certain NGOs to continue conducting them during the conflict. At night, perched in the forested hilltop overlooking the district headquarters, the then-“Royal” Nepal Army (RNA) would rattle machine gun fire into the night sky, largely to flex their muscle and to remind *Maobādi* (Nepali: Maoists) who hid in the nearby jungles that they remained vigilant. Short chains of pink fiery dots fading into the sky accompanied the echoing bursts. “Nobody should have the habit of that noise in their life,” my friend Yutol said one evening, gesturing to two young children who, in their play, imitated the firing of guns. Yutol was a village health worker (VHW) who was trained and, at the time, employed by one of the NGOs helping to organize the health camp. Her father had been a well-respected member of their village, but he was also a high-ranking Maoist who had been taken from their house one day and disappeared by the Nepali Army.<sup>4</sup>

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<sup>4</sup> In an amazing display of providence, Yutol, herself, managed to survive not one, but two pressure-cooker bombings while sleeping inside the NGO’s guesthouse where she lived and worked. The first one, the Maoists admitted, was an accident. A soldier carrying the bomb, which was meant for a government office close by, allegedly needed to hide briefly behind the guesthouse when it accidentally went off.



**Figure 1.1** Long lines form early at the “mother of all health camps” in Humla district, 2004.  
Source: NGO website.

On the day before the camp began, I was helping Yutol clean the hospital when a couple came running towards the building. A mother carried their infant son wrapped in a blanket, which she thrust into the hands of one of the Nepali government health workers (GHWs) who brought the child inside without a word, as if he was familiar with this scene. The father sat on the ground gently sobbing, and began to prepare a pipe full of *kakaD*, a local tobacco. By then one or two others had gathered, and he told us his story of trying to bring their son who was sick with diarrhea to the camp for the past seven days after hearing on the radio that *bideshi* (Nepali: foreign)<sup>5</sup> doctors would be there. The family had great hope that these doctors would be able to cure their infant, who was listless and weak from diarrhea, and so instead of seeking care at the nearby health post, they had decided to wait for the camp. He and his family lived a two-day walk away, but Maoist soldiers had stopped them at a check post just outside the district headquarters, where the health camp was established, doubtful of how sick the infant truly was. In Maoist-controlled areas during the conflict, permission to move about freely was restricted, so

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<sup>5</sup> *Bideshi* is most commonly translated in Nepali as “foreigner,” with “*bi*” meaning “outside” and “*desh*,” meaning “country.” The “*i*” at the end turns the word into a proper noun, conveying the meaning ‘one who is from outside the country.’

the man pleaded with the soldiers to let them pass. After writing down the couple's names and ward number, the soldiers allowed them to proceed to the health camp with their worsening infant, but only after they had agreed to bring back some of the medicines they received at the camp as a fee, which the soldiers said they would come to his home to collect. "Three of our four children have already died," he said, looking directly at me, and I sat with him and the other men, feeling useless for not the first time that day. Yutol and the government health worker tried desperately inside the dimly lit hospital room to find a vein for the butterfly needle in the severely dehydrated infant, but to no avail. In this setting of privation and structural violence, this tragic mix of politics and triage cost this family their third child.

For the remainder of the camp, this family—and so many others—would attempt to store up as much medicine as possible. Some of it would be for future Maoist 'tablet tax' and other medicine would be stored for use by the family. A few tablets might be sold to the nearby pharmacy for money, which would then be used to purchase food and other consumables. Still other medicines would be given to people too sick or too busy in the fields to walk to the district headquarters. Even after the health camp had gone, the social and political lives of the medicines distributed there would extend beyond the discrete medical event—circulating throughout the district, these power-filled objects with inherent and ascribed meaning, are now more mobile in rural parts of Nepal because of medical volunteer programs and health camps.

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Six years later in August 2010, while conducting dissertation fieldwork I sat on a stone wall constructed outside the Humla district headquarters' food depot, observing a group of roughly 500 people waiting to purchase subsidized food aid rice that had been flown up by the state-run Nepal Food Corporation (NFC). There was a lot of commotion at the distribution event, and people shoved and shouted, even threw punches and stones, as they tried to position themselves closer to the doors of the building. Many people spoke of the "tension" (*kati tension bhayo!*) they experienced as they walked great distances and waited on long lines for food aid, which they regularly critiqued as not tasty or dissatisfying: "*Dui choti pisab gareko yasto bhāt gāisakyo,*" I heard on several occasions (You pee twice and this rice is gone). While by some estimates aid rice only accounts for a small percentage of consumed calories in Karnali districts like Humla

(Adhikari 2008: 181), the rice is heavily sought for a range of other reasons, such as for ritual purpose, for home-brewed alcohol, to trade for other foodstuffs and goods, and to supplement unpredictable and sometimes meager harvests. The end of summer in Humla can be an especially trying time as families consume the last of their winter harvest, and monsoon rains keep relief flights from reaching Humla's precarious mountain airstrip.

I watched the rice distribution event underneath a large painted sign that is routinely ignored. It reads:

“होइन चामल रक्सी नै पार्नलाई, चामल हाम्रो भोक नै टार्नलाई”

“Rice is not [really] for making alcohol; Rice is [actually] for satisfying our hunger.”

“Hey, look at that one over there,” a group of women yelled, as a teenage boy tried to cut in line. “*Ghusyo! Ghusyo!*” (He's entered! He's entered!), they yelled, and several men and women yanked him out of the line and tossed him to the ground, even trying to wrest from his hands the ration card that would get him five kilograms of food aid rice for every member of his family at the depot. At least, this is the NFC policy, though it is widely known that social and political connections, as well as one's ethnicity or social status, can also determine the amount of food aid received at the depot. A dozen police officers protected the doors to the building, wielding batons to push back encroaching crowds and to brake up other skirmishes (Figure 1.2). Some families were denied food aid because their ration card had been ripped, and told they should go return with a laminated copy. Others with intact cards were told they had to wait, because of their dirty clothes, a marker of their perceived low caste, several men suspected aloud. Still other attendees had brought hand-written chits from local politicians, which—it was widely known—would fetch more than their 5-kilo allotment. Other family members waited by the barbed wire gates of the depot compound, some with goats, sheep, yak-cow hybrids, horses, and mules to carry the 40-kilogram bags of rice back to their villages. Small, impromptu markets also cropped up outside the compound, and people bought, sold, and traded chilies, cauliflower, tobacco, apples, peaches, apricots, and plums.



**Figure 1.2** Police break up skirmishes outside the Nepal Food Corporation depot, Humla 2010.

The depot ran out of rice after two days and many people went home empty-handed. I spoke to one man who walked for two days to reach the depot, and he ended our conversations with a handshake that must have lasted for thirty seconds, smiling, his eyes saw straight through to my discomfort as I imagined we both were thinking the same thing: that I never had to wait on line for food, and that I was wealthy beyond his imagination. Then he asked me—as so many others would come to ask me as I watched these events over the course of my research—“*Tapāiko desh mā tyasto hunchha?*” (Does this happen in your country?). I replied that there were indeed many hungry people where I came from, and people waiting in lines for meals was not an uncommon occurrence, but he did not seem to believe me. “*Hāmi bhikāri bhaechha*” (We have become beggars), he said, and walked off. A police officer approached me shortly after to offer another view of the scene: “There is a big problem when the rice needs to be protected from the people.” “*YahāN ta khatam chha,*” he said succinctly, (Here, it’s just finished), referring quite clearly to the livelihood situation in Humla, as opposed to the rice that had run out.

## Questioning “Better than Nothing”

Short-term humanitarian interventions such as medical volunteer stints, health camps and food aid programs emerge most saliently in this context—where contemporary histories of violence and disenfranchisement couple with widespread conditions of poverty, sickness, and hunger. Against this backdrop, the provision of free medical care and food aid by any group necessarily represent more than just humanitarian gestures of goodwill or attempts to improve health and wellbeing. Emergent within a particular historical political and economic moment, these short-term models of care—and the growing assemblages of organizations that implement them—occupy prominent but ambiguous spaces in the humanitarian, development, and global health landscapes of Nepal, as well as in the lives of their intended beneficiaries.

This dissertation does not review international medical humanitarianism or food aid practice and policy in historical context. Rather, I focus on the experiences and ideas that surround three specific models of care that have emerged as, what I believe to be, the most prominent forms of intervention in the district where I have worked and conducted research since 2004. I am also not arguing against the judicious use of medical care or food aid. To do so would deny the unquestionable role these interventions can play in improving health and wellbeing, and in addressing acute instances of hunger in complex settings. More importantly, it would deny the people of Humla’s cries for access to this medical care and food aid, as imperfect, episodic, and potentially detrimental as they well know these interventions to be. This dissertation is, therefore, an attempt to shift the focus to understanding the ways these ephemeral events of care condition the lenses and shape the life chances of those intended to benefit from them, and ultimately argues for a centering of these issues in matters of policy.

Researching food aid programs and health camps, as well as participating in camps as a medical volunteer, has also led me to question the broader ethics, limits, and benefits of these short-term models of care. What are some of the potential unintended consequences—social, cultural, biopolitical, medical, and agro-pastoral—of episodic interventions, especially during times of conflict or post-conflict, as arbitrary as these lines can be? Whose needs do medical volunteer stints, health camps, and food aid programs serve or overlook? Do they improve health, and do they address hunger? Are these fleeting events indeed “better than nothing,” as I heard time and time again from those who conduct them, and periodically from those who attend

these events? What are the material circumstances that allow us to even ask such a question? And what has this saying allowed and apologized for, or conditioned?

This dissertation is an initial attempt to answer some of these questions, as well as pose new ones for future research. At a pragmatic level, I seek to reveal the possibilities and challenges of short-term development work and humanitarian efforts in remote and war-torn Nepal by exploring the ways in which the politics of health(care) and food (aid) become inextricably linked in new ways through short-term medical volunteer programs, health camps and food aid programs run by international organizations, security forces, and the state. I seek to contribute a critical, nuanced, and grounded analysis of contemporary models of short-term care in a specific historical and regional context. I do this by examining how the continuous presence of these models of intervention contributes to the transformations in politics, practices, and values surrounding their use and usefulness. Short-term medical volunteer programs, health camps, and food aid programs offer important departure points for opening up discussions about the inextricability of health and hunger, the politics and partitioning practices of short-term interventionism, and the resilience of communities living in the global margins. While there are signs that these fleeting forms of care—packaged as “better than nothing”—create new inequalities and guide aspirations for a better life, there is also evidence that people in Humla living through these episodic events and with the (after)lives of these aid commodities are able to meet their needs using creative strategies.

## **Theoretical Framework**

This dissertation draws from and builds on integrated bodies of literature from four main thematic areas: (1) Critical Medical Anthropologies of Health and Hunger; (2) Critical Development, and the Nongovernmental Government of Care; (3) Global Health Care Chains and the Growth of International Short-Term Medical (Volun)tourism; and (4) The Social and Political Lives of Medicine(s) and Food (Aid). Throughout the dissertation, I weave relevant literature together with my data analysis and discussions as opposed to separating them out.<sup>6</sup>

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<sup>6</sup> I attempt this ethnographic *bricolage* taking a cue from Teresa Mare’s (2011) dissertation, “We Are Made of Our Food: Latino/a Immigration and the Practices and Politics of Eating.”

However, below I outline separately the thematic areas and key concepts and terms that inform my analysis of contemporary forms of ephemeral care in the following chapters.

### ***Critical Medical Anthropologies of Health and Hunger***

Early ethnomedical writings on Nepal focused nearly exclusively on the socio-behavioral, cognitive, and structural-functional aspects of faith healing systems for local communities (Hitchcock and Jones 1976; Miller 1997 [1979]; Peters 1979, 1981; Sagant 1997). This analytically restrictive scope often came at the expense of analyzing local and global relationships of power, and exploring how sickness, health, and plural medical systems were impacted by these dynamics. Only in recent years have scholars begun to critically address the cultural politics of health, health care “development” (*bikās*), and plural medical knowledge and practice in Nepal (Adams 1998; Bezruchka 2000, 2006; Cameron 2008, 2010; Harper 2002, 2003, 2006; Pigg 1992, 1996; Subedi 2001, 2008, 2010). My study draws from and builds on these scholars, as well as the work of others discussed below.

This study recognizes the range of critical medical anthropologies—biocultural, critical interpretative, and political ecological—that offer a holistic approach to understanding individual and collective experiences of health and hunger in specific historical and environmental contexts, broadly conceived. My orientation to understanding these experiences conceives of the mind and body as existing inseparably in changing biosocial and political economic states of wellbeing and dis-ease. I, therefore, draw on Nancy Scheper-Hughes and Margaret Locke’s (1987) heuristic of the “mindful body,” which posits that the idea of the body may be viewed in three productive and overlapping ways—the individual body, which experiences states of wellbeing, sickness, and suffering on a bio-psychosocial and phenomenological level; the social body, through which the social worlds people inhabit are perceived and (re)ordered; and, lastly, the body politic, which sees the regulation and control over individual and collective bodies as productive of the unequal social relations in which the first two bodies are experienced. Lastly, then, the critical lens I cultivate recognizes the importance of ethnography to matters of policy, and seeks to reveal, at multiple levels, the deeply historical relationships of power and inequality that shape these embodied experiences, and ultimately structure and confine life chances in predictable and

asymmetrical ways (Baer *et al.* 2003; Farmer 2003; Morsy 1996; Rosebury 1988; Scheper-Hughes 1992).

This asymmetry is captured by the concept of structural violence, which was conceived by Johan Galtung (1969) and popularized by Paul Farmer (see also Castro and Singer 2004). The idea of structural violence speaks directly to the ways that transnational policies and projects translate into non-random assaults on health, human dignity, and people's aspirations on the ground. It is, therefore, a framework crucial to my study of sickness and hunger during and after times of war in the remote mountains of Nepal. As a Harvard trained physician-anthropologist, Dr. Farmer is one of the people I credit most for my desire to pursue training in medical anthropology and public health. Though I have come to recognize and share certain critiques of his work and the work of his co-founded global health organization, Partner's in Health (Dubal 2012; McKenna and Baer 2012), I am one of countless students who have been inspired by his trenchant writings on health and human rights, and by his exhortations for pragmatic solidarity as a model for contemporary global health efforts. I take very seriously the theoretical implications of his statement: "It is doubtful that the destitute and sick have much to learn from us...but there is little doubt that, as their students, we can learn to better convey the complexity and historicity of their messages" (2003: 242). His inspirational aura is a topic I take up further in chapter four in discussing the growth of what I call "medical voluntourism" in Nepal (Citrin 2010), and other countries throughout the global south.

Farmer's (2003) work elucidates the historical 'pathologies of power' that strip marginalized and power-distant communities of their agency—defined as people's ability to actualize desires and take action to affect the worlds they live in, and, to borrow from Amartya Sen (1999), to create lives they have reason to value. Farmer reminds us that the various forms of everyday and extreme suffering—from beheadings during times of war to the burdens of infectious disease and the gendered allocations of food within the home—are 'structured' by "historically given (and often economically driven) process and forces that conspire—whether through routine, ritual, or as is more commonly the case, the hard surfaces of life—to constrain agency" (Farmer 2003: 41). In the case of those seeking an end to sickness and hunger in Humla, people's agency are limited by enduring histories of internal colonialism and exploitation combined with contemporary conditions of grinding poverty and deprivation. These constraints

are rendered visible by the stories and experiences of those whose lives are at the center of this dissertation.

Farmer's theoretical and methodological orientations are steeped in the tradition of Rudolf Virchow, who was one of the earliest physician-anthropologists to argue for making medicine as much of a social science as it was a cellular science. Concerned with the "making social of disease" (cf. Frankenberg 1980)—that is, of seeing socioeconomic inequality as the ultimate determinant of poor health and disease—Virchow advocated for more political economic understandings of disease etiology and epidemiology. McNeil (1976) later described this as the process of establishing the interrelationships between various forms of micro- and macroparasitism (see also Brown 1987). Microparasitism refers to the tiny organisms (bacteria, viruses, worms) that live on and reproduce in the human body, while macroparasitism refers to the social and economic relations that find nourishment in human labor and exploitation, which are the ultimate cause of ill-health and disease (Engels 1958 [1845]: 170-184; Baer *et al.* 2003: 6). Over a century and a half ago, Virchow presciently stated that "the improvement of medicine would eventually prolong life, but improvement of social conditions could achieve this much more rapidly and successfully" (cited in Waitzkin 1983: 62). In light of the unrelenting disparities in health status and access to prudent and affordable medical care that have come to characterize the most recent decades of "global health," Virchow's words indeed appear prophetic (DeWalt and Pincus 2003; see also Eisenberg 1984; McKenna 2012).<sup>7</sup>

I also draw upon the work of Nancy Scheper-Hughes as I examine the medicalization of hunger and other unmet basic needs through the "irrational drugging of sick-hungry populations" (1992: 203) that occur at health camps and through medical volunteer programs in Humla. Ivan Illich (1975: 31) first famously described the "medicalization of life" that occurs when medicine is used to both solve problems that should be addressed in other ways, and create ones that were never there to begin with. Scheper-Hughes' beautiful and wrenching ethnography *Death Without Weeping: The Everyday Violence of Life in Brazil*, discusses how there is a utility in the silent—and silencing—slippage of subjectivity that occurs when one goes from being hungry to sick: "A hungry body needs food," she writes. "A sick and 'nervous' body needs medication." A hungry

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<sup>7</sup> Yet, despite his strong influence on Franz Boas (1902: 41), who praised Virchow's "rare combination of a critical judgment of greatest clearness and thoroughness...and a genius for grasping the causal relation of phenomena," the political economic perspective of health that Virchow [and Friedrich Engels] fostered would not draw serious attention in medical anthropology circles until the 1970s (Baer *et al.* 2003: 19).

body exists as a potent critique of the society in which it exists. A sick body implicates no one” (Scheper-Hughes 1992: 174). This serves as a perfect frame for thinking about both medical camps and food aid programs, which both have the cumulative effect of stripping the conditions that foster poverty, scarcity, sickness, and hunger of their human origins and turning them into problems solvable by dispensing medications or food in the short-term. My study follows a similar analytic line as Scheper-Hughes by exploring some of the reasons why, in the context of Humla, so many “chronically hungry people ‘eat’ medicines while going without food” (*Ibid*, 177).

### ***Critical Development, and the Nongovernmental Government of Care***

To frame my analysis of the growth of short-term models of care in Humla, I situate this study within recent anthropological writings on nongovernmental and humanitarian governance (Fassin 2007a, 2007b, 2009; Fehrer 2007; Ferguson and Gupta 2002; Rose and Miller 1992) and increasingly complex states of emergency (Barnett 2011; Bornstein and Redfield 2010; Fassin and Pandolfi 2010). I also draw from critical development scholars who examine the “apolitical politics” (Fisher 1997: 444) of supposedly nongovernmental organizations whose growth is traceable to neoliberal shifts in funding in the 1980s and 90s, when NGOs were inserted into the global development apparatus (Escobar 1995; Ferguson 1994) as general purveyors of ‘doing good’ in countries ruled by supposedly corrupt and inefficient governments (Fisher 1997; World Bank 1995: 40, cited in Ahmad 2006: 187). In addition, this work builds on important recent anthropological writings on neoliberalism and nongovernmental governance as it relates to various forms of tourisms (Batista 2012; Garland 2012; Mathers 2012).

In Humla, as in other Karnali districts, NGOs and other development institutions and state relief agencies have begun to consolidate control over and access to the basic material and non-material resources that enable life chances in Humla. Among these I include ample, self-determined sources of food, education, basic health care, employment,<sup>8</sup> dignity, and hope. In these very specific ways, NGOs in Humla often find themselves governing (counting, controlling, managing, servicing, maintaining) the populations they seek to aid (Feldman and

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<sup>8</sup> In 2002, Saubhagya Shah estimated that somewhere between thirty and forty thousand Nepalis were employed in the NGO/development sector (147). Surely, by now this number has soared to three or four times this estimate, depending on your criteria of being employed.

Ticktin 2010; Hyndman 2000). When this happens, “it becomes all too clear that ‘NGOs’ are not as ‘NG’ as they might wish us to believe” (Ferguson and Gupta 2002: 101; Edelman and Haugerud 2005: 27; Fisher 1997: 451), and that they are powerful actors in what Feldman and Ticktin (2010) call the new “government of care.” My study draws from and builds on the work of these authors to explore how the explosion of development, humanitarian, and aid organizations in Humla engaged in short-term models of care have both expanded and disaggregated the channels through which people have come to expect its delivery.

In Humla, the rise of “the new medical NGOs” (Adams 1998: 189) represent an emergent model of government, or what the late Nepali anthropologist Saubhagya Shah (2002: 156) aptly termed a “Nepali NGOdom.” The play on “kingdom” resonates in the Nepali context because of the sweeping power the 240-year-old institution of monarchy held in the country and, in particular, because of its recent abolition by a then-Maoist-led government in 2008—turning the only Hindu kingdom into the world’s newest federal republic. Indeed, more and more it seems like a republic ruled by NGOs beyond the purview of a putatively absent state.

Michel Foucault has articulated two key concepts on which scholars of critical development, NGOs, and humanitarian organizations have productively drawn. His notion of biopower elucidates the historical ways in which our vital (biological) and social lives have emerged as the ontological order through which people are made—and in turn come to see themselves as—subjects of systematic calculation and control (Foucault 1990 [1978]: 143; also Ong and Collier 2005: 6). For Foucault, new disciplines of the body—the health sciences, such as public health, demography, and mortality studies—gave rise to new forms of surveillance, controls, and medical examinations, which were indispensable to the advent of modern industrial capitalism. In much the same way, the modern humanitarian apparatus—of which NGO- and state-run health camps and food aid programs represent stark examples—has brought into its realm the many diffuse technologies of care that take life, and “saving it,” as their objective (Foucault 1978: 152; Agamben 1998).<sup>9</sup>

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<sup>9</sup> Early critical development scholars tended to characterize the power of the “development apparatus” as all encompassing as it “depoliticizes everything it touches, everywhere whisking political realities out of sight, all the while performing, almost unnoticed, its own pre-eminently political operation of expanding bureaucratic power” (Ferguson 1994: xv). Sivaramakrishnan and Agrawal (2003: 29) argue that this claim is hard to justify, and similarly hard to link to the theorizing of Foucault (1990 [1978]: 95), for whom power maintains a more “relational character.” The simple adage of where there is power, there is resistance (*Ibid.*, 95) is important, but more important for Foucault is the realization that power operates and is challenged from multiple points, and is “seldom exercised only institutionally” (Sivaramakrishnan and Agrawal 2003: 29).

In this dissertation, I also build on and expand Foucault's related concept of "governmentality," a concept he proposes to refer to the ways of thinking and acting embodied in all these attempts to know and govern the health and wellbeing of populations (Rose and Miller 1992: 174). What I am particularly interested in are the ways that NGOs do this by mitigating—but not addressing—unmet basic needs of populations through short-term aid and relief; and how the intended beneficiaries of this aid both deploy and deny these subjectivities in the face of a growing network of institutions and agencies, including the state, and their various discourses and techniques for the disciplining and care of the self. The growth of humanitarian groups that conduct health camps and food aid programs in Humla have become part of the network of humanitarian assemblages that register what Peter Redfield (2005: 344) refers to as a "minimalist biopolitics": the wielding of "tenuous administration and control over survival within circumstances that do not favor it." In this, we see the possibility of humanitarianism to both help and undermine by 'preserving existence at the possible expense of deferring actions that might support a mode of being more consistent with dignity' (*Ibid*, 330). Acting on particular bodies and minds, the social, material, and (bio)political effects of short-term medical volunteer programs, intermittent health camps and food aid programs can be obscured in the "haze of humanitarianism" (Pandolfi 2010: 228). Lost in the unassailable moral logic of 'saving lives' are the ways that these fleeting forms of care constitute new forms of transnational governance (Ferguson and Gupta 2002) that both emerge from and perpetuate the retreat of the state, and simultaneously (re)shape local experiences of health, hunger, and hope for improved livelihoods.

Nguyen describes one of these forms in his discussion of the "complex biopolitical assemblage" that emerged around the AIDS crisis, when governments, international aid donors, pharmaceutical companies, and humanitarian organizations merged around a moral and vital challenge. It has resulted in an "increasingly biomedicalized form of governmentality," with NGOs leading the coalition that Nguyen (2005: 126) refers to as the humanitarian/development complex:

a specialized and highly structured crystallization of broader, more diffuse transnational processes wherein a diversity of groups, often referred to as nongovernmental organizations (NGOs), involved in a plethora of activities ranging from advocacy to service delivery, coalesce across different settings around different issues.

In Humla, the humanitarian/development complex is manifested in the public private partnerships (PPPs) created so that NGOs can run district hospitals, or serve as the delivery mechanism for United Nation WFP aid rice distribution through food-for-work (FFW) road building projects. How has the continued use of something typically intended for times of crisis or emergency served to further blur the boundary between humanitarianism (supposedly short-term) and development (ideally long-term) work amidst ambiguous states of “emergency” or “post-conflict” zones? And, how have these frames come to operationalize certain models of care events that condition expectations and practices on the ground?

The temporal contours of crisis and emergency have been similarly reworked by Redfield (2010), who looks at the work of *Medicins Sans Frontiers* (MSF)—known more broadly in English as Doctors Without Borders—to examine the ways in which humanitarian action increasingly responds to less spectacular forms of everyday sickness and suffering in more diffuse settings; places, he suggests, that are closer to the “verge of crisis” where “the emergency remains emergent, its temporal form an ‘almost now,’ rather than a vital present of pure action” (Redfield 2010: 191). These authors all illuminate the ambiguities and “gray zones” that surround humanitarian action (Pandolfi 2010: 227), especially when the emergency or crises becomes a state of suspended exception, and where the responsibilities of a sovereign state—to feed populations and protect them from sickness—are conferred indefinitely on so-called non-state groups like NGOs and the host of foreigners who come to ‘do good’ in Nepal.

### ***Global Health Care Chains and the Growth of International Short-Term Medical (Volun)tourism***

*You might think this mission to Mugu was glamorous, because after all it is a sort of backpacking trip with surgery thrown in. Possibly the ultimate way to trek, right? After this first trip, you would never think that way again. Two weeks is a long time to go without hot water or plumbing if you are not used to it, and the fun disappears quickly when your patient is suffering. ‘Hard core’ is a better term. Not just anybody can be on the team...*

~ An excerpt from *The Hospital at the End of the World* (Niemczura 2009)

International short-term, volunteer trips are a burgeoning form of medical travel that involve temporary programs, educational opportunities, or service electives in resource poor settings (the

global South) by students, tourists, and clinical professionals from rich countries (the global North). Birrell (2010) has called *voluntourism* the “fastest growing sector of one of the fastest-growing industries on the planet” (see also Sherraden *et al.* 2008), with the kinds and destinations of volunteer trips expanding at an unprecedented rate. As a result, a range of neologisms has cropped up around the phenomenon, such as “guilt trips,” “philanthrotravel,” “poorism,” “alternative tourism,” “developmentourism,” “volunteer tourism,” or “volunteerism.” Located at the intersection of circulated humanitarian discourses of suffering and a Western sentimentality of ‘doing good’ (Richter and Norman 2010), these trips are an emergent form of global interaction. In particular, short-term medical volunteer work provides insight into contemporary “global health care chains” (Nichter 2008a: 173), which are characterized by the growth of new and unequal movements of medical ideas and ideologies, resources and technologies, and personnel in an increasingly globalized world marked by inequalities in health status and wellbeing.

The term “medical tourism” commonly refers to the crossing of international borders to have access to cheaper, often specialized, medical services.<sup>10</sup> I use the term voluntourism here in the sense that Stephen Bezruchka (2000: 77) first coined the use of the phrase “medical tourism” to refer to “short-term overseas work in poor countries by clinical professionals from rich countries.” Holtz (2009: 111-113; see also Mackinnon 2009: 23) describes these short-term international health care stints as anything short of long-term commitment to changing the actual conditions that promote health, and where volunteers often “treat themselves”—making oneself feel good without offering sustained and mutual benefit to the intended communities.

My dissertation fills a major gap in research on the mobilization of care<sup>11</sup> that has focused on medical tourism by global northerners seeking cheaper services in poor countries, or “the brain drain” effect that has seen such an increase in the movement of nurses, doctors and technicians from the global south to the north (Hagopian *et al.* 2004). I take an in-depth look at the flip—and less examined—side of modern medical travel, which is done by medical and global/public health students or volunteer clinical practitioners engaging in short-term (less than

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<sup>10</sup> A number of guidebooks have recently been published (Bookman and Bookman 2007; Hancock 2006; Kumar 2009; Woodman 2008).

<sup>11</sup> For example, at the annual meeting of the Association of American Geographers in Seattle in 2011, there was a dual panel on “Mobilizing Care,” which examined two of the three trajectories of modern medical travel—(1) health care practitioners from so-called developing countries to developed (also known as the “brain drain”); and (2) medical tourists from the developed world seeking cheaper medical services in poorer countries. Missing was a discussion of health care practitioners working or volunteering for short stints in poor countries.

three months) health care-related activities in the global South, which serves as the definition for short-term medical volunteer work in this study. In chapter four, I take a close look at medical voluntourism in remote Nepal, and examine the social, political, and material implications of their circulations in the district of Humla.

Short-term medical trips have become some of the most prominent volunteer programs, with universities, religious and secular private organizations, and legions of NGOs facilitating a range of opportunities to fit the needs of various participants. Increasingly, the Internet has become the method for finding these opportunities, as numerous volunteers told me in Nepal. A recent *Time Magazine* editorial noted that voluntourism trips are becoming so mainstream that CheapTickets.com has made it possible to book volunteering opportunities alongside flight reservations (Fitzpatrick 2007). A simple search for “medical volunteer” on the website Idealist.org retrieves close to 5,000 possibilities with NGOs in a range of low-income countries. For example, one can now “book a medical trek” to participate in a moving health camp by clicking on a link that will take you directly to a credit card payment site. The medical trek costs USD\$ 2,900, excluding airfare, international health care insurance, accommodations when in Kathmandu, and other personal expenses. The amount of money often required to go and ‘do good’ lends purchase to Ivan Illich’s description of Westerners volunteering in less industrialized nations as engaging in “high levels of service consumption” (Cayley 1992: 94). As advertised by the NGO sponsoring the health care trek, “Anyone is encouraged to participate; medical experience is not mandatory” (Figure 1.3).

**Join Our Treks**

Medical Trek, Nepal | Mt. Everest Base Camp, Nepal | Annapurna, Nepal | Inca Trail, Peru | Ausangate, Nepal

**Nepal: Volunteer Medical Trek**

[Book This Trek](#)

**Trek Summary**

Our popular "Moving Medical Camp" provides basic healthcare and medical treatment. Anyone is encouraged to participate in our treks; medical experience is not mandatory. Our volunteer team will trek deep into the rural countryside on the Langtang Trail and bring along with us the equipment and supplies needed to stay several days in villages and conduct health clinics. On this trip you will see the beautiful countryside of Nepal as well as many of the unique and exciting sites around Kathmandu.



**COST:** \$1,500. Includes virtually all of your in-country expenses such as hotels, transportation, food, tents, etc. Airfare to Nepal is not included. Our sponsor, [Himalayan Trekking & Travel](#), will arrange your flights at very good prices.

**TRIP DATES:** April 17 - April 30, 2011

**Figure 1.3** Booking a two-week volunteer medical trek in Nepal, medical experience not mandatory.

Young people make up the majority of short-term medical volunteers, and many now participate through university-run programs. With the growth of global health departments at universities and health centers, international medical training, research, and service opportunities are on the rise (Crump and Sugarman 2008; Doughton 2011; Kanter 2008). More than one quarter of all US medical school graduates went on international health care trips in 2008 (Green et al. 2009) compared to 6% in 1984 (AAMC 1984), and a recent report shows that 65% of 2010 matriculating medical students planned to participate in global health electives (AAMC 2010). While these trips are often the gateway to future careers in international health (Grennan 2003; Suchdev et al. 2007), there is growing concern about the ethics, benefits, and impacts of these short-term programs among academics, medical professionals, health activists, volunteers, and the communities they are intended to benefit.

There are few quantitative studies examining the impacts of short-term volunteer medical work on health outcomes. The scope of the work and the transience of medical teams spread across the globe make assessing outcomes difficult (Fisher *et al.* 2001). One study examined over 6,000 pediatric anesthesia cases performed in 18 countries by volunteers working with the international NGO (INGO) Operation Smile (Fisher *et al.* 2001). This study was the first large-

scale cohort analysis of anesthetic outcomes during a program of volunteer medical and surgical services abroad. It was found that adverse events such as inadvertent esophageal intubation or cancelation of surgery after anesthesia were low, as were overall cases of perioperative morbidity and mortality. However, the authors also point out that variability in diagnostics and quality of recording data among volunteers contributed to underreporting of adverse events. Another study documented the success of volunteer “medical brigades” in collecting growth status data in children in Honduras. This information, the authors note, will be important for understanding predictors of poor growth and can assist local public health systems to improve nutritional targeting (Oken *et al.* 2004).

Despite a scarcity in studies that quantify outcomes of short-term international medical work, a growing body of literature on the topic has appeared in academic journals (Green *et al.* 2009; Mankamyar 2010; Provenzano *et al.* 2010; Shah and Wu 2008) and popular literature, such as in magazines and travel books (Budd 2012; Fitzpatrick 2007; MacNeille 2006; Niemczura 2009). Discussions surrounding these trips are often impassioned and divisive. Many argue for sustainable models that bring resources, care, skills, technology, and training to places in great need, stressing collaboration with local communities and strong guiding principles (Federico *et al.* 2006; Hall 1990; Khambatta *et al.* 2001; Oken *et al.* 2004; Morgan 2007; Rees 2001; Suchdev *et al.* 2007). Others raise serious questions of accountability, the distribution of benefits and burdens, and unintended social and medical harm (Banatvala and Doyal 1998; Bezruchka 2000; Bishop and Litch 2000; Cam *et al.* 2010; Citrin 2010; Crump and Sugarman 2008; Crump *et al.* 2010; Decamp 2007; Dickson and Dickson 2005; Gray 1992; Grennan 2003; Hoover *et al.* 2005; Holtz 2009; McKenzie 2005; Montgomery 1993; O’Neil 2006a; Scarisbrick 2001; Wall *et al.* 2006; Wendland 2012).

In all these many cases, the authors point out the potential unintended consequences of providing medical care without understanding the local context in which it is understood and sought out. They also suggest that these trips operate in, and perpetuate, a global climate where pills, surgeries, and syringes are championed haphazardly, or at the expense of addressing the basic needs that promote and sustain health. Despite differences in definition and opinion, all agree that the rise in global short-term medical work necessitates further interdisciplinary discussion by all those involved.

Yet, there are compelling reasons to consider the benefits of short-term medical volunteer work for the participants, the local health care institutions, and the intended beneficiaries. The educational and training opportunities are indispensable for the next generation of global health practitioners, and exposure to the global South has been shown to foster an emerging global consciousness (DeCamp 2004; Kiely 2004). Work in resource-limited settings requires cost-conscious thinking and simple diagnostic practices, skills that will serve medical students and residents well in their chosen profession (Barry and Bia 1986; Panosian and Coates 2006; Rees 2001). Several authors also note that global health electives can serve as the basis for establishing strong reciprocal relationships between international medical students and workers, communities, and local health care institutions (Federico et al. 2006; Suchdev et al. 2007).

These volunteer experiences are increasingly the fodder of student journal articles, conference talks, and books. I am, therefore, also concerned with the representations of Nepali people and places that occur alongside the growth of medical voluntourism, as well as its historical precursor, medical missioning, and these representations are woven into my ethnographic discussions throughout this dissertation, especially in chapter four. Particular to Humla are representations that make use of and perpetuate a discursive tension between a land both beautiful and impoverished, a Shangri-La and a country in need of development. As Nichter (2008: 5) reminds us, representations matter in the increasingly biopolitical fields of global health and humanitarianism, especially, as he notes, when ‘the social life of health-related representations become social facts employed strategically in the interpretation of ill health or in the justification of health care interventions.’

### ***The Social and Political Lives of Medicines and Food (Aid)***

My study also builds on and expands the theoretical work of Appadurai (1986), Whyte *et al.* (2003), Holtzman (2009), among others to explore the active social and political lives of health camp medicines and food aid rice in Humla. I consider these aid commodities here in the broad sense that Marx (1971 [1887]: 26) initially introduces the idea:

A commodity is, in the first place, an object outside of us, a thing that by its properties satisfies human wants of some sort or another. The nature of such wants, whether, for instance, they spring from the stomach or from fancy, makes no

difference. Neither are we here concerned to know how the object satisfies these wants, whether directly as means of subsistence, or indirectly as means of production.

Needs of the body and soul, and a hunger to nourish both, compel people in Humla to seek out aid commodities, and I look specifically at their social lives and how they circulate in different regimes of value and, with regard to food aid, taste (Appadurai 1986: 4-5; Bourdieu 1984). In other words, I examine how they are sought out, exchanged, eaten, sold, and traded between social actors, moving from one setting to another. As they do so, they become meaning-filled objects with economic value, and resources with political purpose, especially during times of conflict, as the story of the camp attendee who was in need of medicines to give to the Maoist soldiers for safe passage back home reminds us. It is in these exchanges where the social use value of things emerges (Marx 1971 [1887]: 48), and so following the material things themselves shows how their meanings are inscribed in their forms, their movements, and their multiple uses (Appadurai 1986: 5).

Health camps and food aid distribution events act as important nodes—quite often the first—in the exchanges and value chains of flown-in medicines and food, catalyzing their movement to certain people and places while, at other times, restricting their access and flow. Quite frequently, they end up in the hands of those who can most afford them (Adhikari 2008: 180; Hartmann and Boyce 1979: 46), are in positions of influence or power, or who have friends and/or family members in these positions (Whyte *et al.* 2004: 22). Therefore, food aid and medicines are also markers of status and inequalities in Humla, just as they are also commodities with a range of perceived effects on the body. Precisely because these interventions are events where food and medicine are given out, often for free (in the case of health camp medicines) or at a subsidized rate (as with food aid), they become highly charged socio-political and health-related events.

In their book, *Social Lives of Medicines*, Whyte, van der Geest, and Hardon (2003) encourage new anthropological inquiries into the increasingly mobile forms of *materia medica*, and the dynamics of their movement and meanings through increasingly commercialized networks, informal channels, and the meeting of the two.<sup>12</sup> Harper (2002: 144) has discussed the

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<sup>12</sup> As Whyte *et al.* (2003: 11) note, scholars have already made important contributions to these domain of social and critical inquiry, for example Ferguson (1981), Nichter (1980), and Fassin (1987).

growing awareness of and demand for medicines that has emerged alongside their hugely increased mobility and material availability in Nepal. Charting the various “courses of medicines”—in both senses of the word—in rural Nepal as a result of health camps, for example, brings to light what people do with them after the doctors and helicopters are gone, an important and underexplored topic. For, while medicines are obvious and powerful symbols and tokens of hope for people in distress, they can also be markers of inequalities (Singer 2008). Who benefits from their increased availability, how, and in what ways? As Whyte *et al.* (2003: 9) note, anthropologists are uniquely positioned to explore not just how and where they move, but why they move in the context of shifting social relations and how, in turn, their movement shapes those social relations. This framework has been important for thinking through some of the problems and potentialities surrounding the often-haphazard distribution of drugs as a result of health camps—as well as many short-term medical volunteer interactions—in situations where medicines come to be in great need, while also coming to stand in for unmet needs.

And, like medicines at health camps, food aid distribution events occupy similar social and political spaces. Flown-in food aid is made into alcohol, given as gifts, used for rituals, and sold for money. It is received in greater quantities with chits written by politicians, and denied or given in smaller portions to those whose caste displeases the staff. Aid rice is eaten and commented on regularly (both with and without prompts by ethnographers), is unpacked and examined in public spaces, carried on pack animals through villages, and distributed in and between them according to local systems of resource sharing that confound notions of “targeting.” The articulations of the differing values of food aid in Humla are often rendered visible in the circumstances of their use, exchange, and receipt; and to be sure, where the food comes from matters.

In his insightful ethnography, *Uncertain Tastes*, Holtzman (2009) explores the ways in which, for the Samburu of Kenya, newly introduced foods become classified as “gray foods,” “poverty foods” or “government foods,” creating great ambivalence around changing relations of subsistence and society. As the pastoral ways of the Samburu are increasingly incorporated into a cash economy, the memory of what eating used to be contends with the consumption of such gray foods borne out of both necessity and choice. My study similarly examines some of the ways that food aid has contributed in Humla to changing foodways—by which I mean the ideas, values, and practices around growing, procuring, cooking, and consuming food, as well as how

diet and taste shape and are shaped by social, political and economic relations. Holtzman (2009: 205) found that women often end up brewing alcohol with relief foods, which casts them both as ambiguous figures that promote questionable moral choices, and become doubly suspect for earning money while doing so; even when the money these women earn typically goes to buying other foods of choice for families. Gray foods, then, may also be an appropriate metaphor for the ‘gray zones’ of humanitarian need, where material commodities like medicines and food aid are introduced into communities presumed to be lacking basic needs, and in turn introduce new dynamics to specific and critical forms of exchange related to basic subsistence and wellbeing (Holtzman 2009: 225).

Finnis *et al.* (2012) propose the similar concept of “marginal foods” to examine how food tastes, dietary preference, and culinary practices among “non-elites” (e.g., indigenous groups, migrants, recipients of humanitarian aid) are shaped by social, cultural, political economic, and geographical forces in specific places and historical moments. As Wilk (2012: 15) notes, a food may be considered marginal because it is “extremely common, cheap, and low in status...limited in seasonality or distribution, or highly perishable.” Food may also be considered marginal because of who eats it and why. This perspective is particularly relevant to an exploration of the seeking out and using of food aid in Humla. Tensions surrounding taste and social boundaries and identities emerge in the procurement and preparation of food aid, which ultimately contribute to the (re)imaginings that happen around growing and eating traditional crops and new cuisines, and in figuring out what may be considered “marginal” or “good food” (Brett 2012: 159).

To my knowledge, there have been no studies of the circulation of aid commodities after they are distributed, and the ways in which their pursuit and usages shape experiences of health, hunger, hope, and wellbeing. By exploring the social and political lives of health camp medicines and food aid rice within the range of active responses to sickness and hunger, my study fills a gap in research around short-term models of care by mapping the experiences, as well as the traces and (after)lives, of these interventions, examining processes shaping the very ‘commodification of sustenance and survival itself’ (Holtzman 2009: 224). This ethnography of ephemeral care contributes to an expanded understanding of how aid commodities come to have meaning and use outside those immediately associated with humanitarian relief or medical treatment in settings of structural violence and great need. Thus, if, as Appadurai (1988),

suggests, ‘things have biographies’ we stand to learn a good deal about the fluid meaning of medicines and food aid as they relate to the targeting of sick and “food insecure” people in the context of basic needs unmet and redefined.

### **Health and Hunger, a Note on Terms**

Throughout this dissertation, I use the word “hunger”—*bhok* in Nepali—instead of the term “food insecurity,” unless addressing the phrase in other literature, official discourses, or in reported speech. The phrase for “food insecurity” in Nepali—*khāddhya asurakshā*—is not used in conversation outside the corridors of large institutions or NGO offices. Beyond this, hunger is something that is experienced and expressed in a range of ways, many of which fall outside the statistical acrobatics of food security rankings and vapid expressions of intrapersonal kilocalorie variation. As Mary Douglas (1984: 498) reminds us, the concept of nutritional wellbeing turns out to be an extremely difficult idea to study quantitatively, and is perhaps best approached from an anthropological perspective that takes account of social, cultural, political and agricultural contexts more broadly. Thinking about hunger as inextricable from concepts of health and wellbeing is an important theoretical and methodological shift, and one that may be complimentary to the “thorny problem of measuring” hunger (*Ibid*, 498). It is ultimately a shift I will come to argue as invaluable to a new ‘bread and butter politics’ (Watts 2001) in a contemporary age of short-term care.

These days, Humli people speak regularly of *bhok*, and quite frequently of “famine” (*bhokmāri*), especially when village elders recall the ‘old days’ when having enough food to eat was, in their eyes, less of a problem. And, though I suggest throughout this dissertation that discussions of hunger are—in some ways and at certain times—‘metaphorical’ of various kinds of discontent—local and global, as well as social, political, and gastronomical—in no way does this signal my turning away from the plain facts of hunger as a lived, embodied experience (Scheper-Hughes 1992: 132). Rather, I seek to acknowledge the material and corporal realities of under-nutrition and unfulfilled human needs, while also recognizing that experiences of hunger are also sadly symbolic of life in Humla—known as the “Hidden Himalayas”—where many people hunger for a better life, or the life they see others lead.

In Humla, Nepali UN WFP officers periodically walk through the district to conduct evaluations of the “food security” situation in Village Development Committees (VDCs).<sup>13</sup> Though Nepali UN WFP personnel are forbidden from giving interviews, I regularly spoke to one in Humla (we can call him Bishwa) who was always quite pleased to confer with me, albeit “*lukaera, gopyatā mā!*,” (Hiding, in secret!) he would say, and then chuckle. In truth, we hid in plain site, sipping cups of strong *raksi*, variably strong home-brewed alcohol made from grains. In our case, the *raksi* we drank at a small hotel in the district headquarters was always made from food aid. The owner of this hotel was very well connected in the district headquarters, and so her apportionment of food aid was steady and ample. “What is the difference between food insecurity and hunger,” I asked Bishwa one day, almost in jest. “Food security,” he said, “gives me my job.”

The concept of food security made its appearance at the first World Food Conference in 1974 (Pottier 1999: 11), and was expanded at the 1996 World Food Summit to be defined as “all time sufficient, safe, nutritious food to maintain a healthy and active life.” This phrase has had the unintended effect of sterilizing the lived bio-psychosocial experience of hunger, and converting it into calculable indices of life, often expressed blandly in units or intake. The use of statistical information and nutritional mapping is, of course, a crucial set of tools for informing policy and interventions that seek to address hunger, though the voices of those with whom I spoke to during fieldwork would suggest that these numbers and studies have failed to fill their bellies.

Calling hunger food insecurity is quite similar to the discursive shifts that occurred in the late 1970s around discussions of Primary Health Care (PHC), espoused in the 1978 Declaration of Alma Ata at the International Conference on Primary Health Care.<sup>14</sup> This important document acknowledged health as a human right; the relationship between poverty, political instability, and poor health; global disarmament as a policy measure geared towards freeing up resources; and the unacceptability of “gross inequality” in poor health status. Further, it ranked specialized medical services and the use of drugs behind a list of preventive components aimed at achieving “Health for All by the Year 2000”—behind education, food and nutrition, sanitation, and clean water. In short, the concept of health was situated firmly within larger struggles for social justice.

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<sup>13</sup> VDCs are the smallest administrative units in districts. Humla has 27 VDCs.

<sup>14</sup> The declaration can be accessed at: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf).

Just one year later, more “narrow strategies of care” based on the cost-effectiveness of vertical, disease-focused interventions were deemed more feasible and—perhaps, more importantly—less political (Janes 2004: 458; Magnussen, Ehiri, and Jolly 2004: 169; Werner 2001: 22). This shift to “selective” primary health care (SPHC) was proposed just one year after Alma Ata as an interim step (Walsh and Warren 1979), but it was a step in the opposite direction. The “era of optimism” dissolved into what David Nabarro (1983: 88) describes as a “sea of platitudes.”

A similar discursive shift can occur when we speak of food security as opposed to hunger; though, encouragingly, institutions like the World Bank and the UN World Food Programme have been discussing explicitly the interconnectedness of health and hunger and the need for expanded views of their interrelated causes and consequences. As noted in a 2007 “World Hunger Series” report by the UN WFP (2007: 28), “health cannot be improved without tackling the problem of hunger; hunger in turn leads to poor health. Many of the causes of hunger also contribute to poor health.” This change in policy tenor can be traced to the contributions of scholars such as Amartya Sen and Jean Dréze who have drawn crucial attention to the need for exploring the interactive relationships between health and hunger by,

broaden[ing] our attention from the command over food to...command over other commodities that have a substantial impact on nutrition and health. A person’s capability to avoid undernourishment may depend not merely on his or her intake of food, but also on the person’s access to health care, medical facilities, elementary education, drinking water, and sanitary facilities (Dréze and Sen 1989: 13).

Health, then, as I use it in this dissertation, refers to having access to and control over the basic material (clean water, ample and self-determined sources of food, education, work, basic health care) and non-material resources (respect, dignity, hope) that promote and sustain healthy and hopeful lives. This definition comes primarily from Baer *et al.* (2003: 5), though also includes the thoughts of Amartya Sen’s (1999) conceptualization of freedoms to engage in processes of self-actualization (political, social, cultural, spiritual, economic), and people having the basic capabilities to treasure the lives they lead. “Unfreedoms,” Sen (1999: 3) notes, come in the form of poverty, tyranny, economic and social deprivation, fissures in public safety nets, prejudices, and, in their various manifestations and combinations, systematically rob people of their ability to lead a life they choose to value. This, I feel, provides an experientially robust definition of health and wellbeing, which necessarily includes the absence of hunger, and the presence of

hope.

Hunger, as I employ the concept refers to the full range of experiences associated with the bio-physiological deficit in required nutrients, alongside the range of concurrent psychosocial emotions, such as anguish, grief, humiliation, and fear (Lappé, Collins, and Rosset 1998: 3). This entails a refocusing around the lived experience of hunger, which discussions of “small but healthy,” “chronic undernutrition,” and “hidden hunger” seem to dilute. I hope this dissertation begins to fill in missing parts of an ethnographic map that will be both representative of the (counter-)histories and lived experiences of struggles for health and against hunger, while also pragmatically useful to those who seek to address the root causes of both.

### **Methods and Motivations, or, On ‘Doing Good’ and Doing Good Enough Ethnography**

*If I am clumsy, that may indicate partly the difficulty of my subject, and the seriousness with which I am trying to take what hold I can of it...*

*If I could do it, I'd do no writing at all here. It would be photographs; the rest would be fragments of cloth, bits of cotton, lumps of earth, records of speech, pieces of wood and iron, phials of odors, plates of food and of excrement...*

*A piece of the body torn out by the roots might be more to the point.*

~ James Agee, *Let Us Now Praise Famous Men*, 1939

In many ways, this is a dissertation about what it means to care, to try to ‘do good.’ This thesis draws from my experiences in Nepal over the past eight years, both volunteering with and conducting research on NGOs, health camps, and food aid programs both during and after times of war.<sup>15</sup> It is through my first hand experiences as a medical voluntourist and as a researcher that I come to understand the phenomenon of short-term care in settings that have become inimical to leading healthy lives, and so what I have to say reflects both the long-term research I’ve conducted and my interpretation of these experiences. The words of James Agee above speak clearly to my feelings about writing of such sad experiences of sickness and hunger. And,

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<sup>15</sup> This includes stays from October – December 2004, July – September 2006, June – December 2007, June – September 2009, and January – December 2010.

therefore, I hope that what I have written here comes across as more than just a biased voicing of ‘motivated truths’ from a ‘less-than-modest witness’ (Redfield 2006).

In order to better understand the emergence of health camps and food aid programs in Nepal, I studied a range of documents and media to triangulate with in-depth interviews and observations, which include policy papers, health camp and food aid reports, radio programs, journal and newspaper articles, organizational websites, newsletters, and videos. The bulk of my ethnographic research was conducted while living in Humla district in the northwest Karnali zone. I adopted a multi-sited approach to fieldwork (Marcus 1995), using snowball and purposive sampling to conduct semi-structured individual and group interviews in Kathmandu and Humla. With permission, and when appropriate, I recorded interviews, taking precaution to ensure anonymity.<sup>16</sup> In analyzing transcripts, I used open coding procedures to engage anew with my data, and to allow themes and a general descriptive framework to emerge through patterns and stories.

These are the stories told by Humlis who so graciously offered up their homes to me and my research assistants, and who shared their food with us even when they had so little. They are also the stories of when I attended food aid distribution events at the Humla district headquarters food depot (*godām*), and waited with people as they queued for hours, sometimes sleeping in the rain overnight to purchase subsidized food aid rice provided by the Nepal Food Corporation (NFC) or the United Nations World Food Program (WFP). Similarly, I spoke to Nepali attendees at health camps, often as they waited on line to be seen, or sat outside for a family member. I observed and spent time with medical volunteers (MVs) in remote hospitals, at health posts and medical camps, during training sessions, trekking mountain trails and, in one case, living with two volunteer physicians for six weeks in two villages. I was drawn inevitably into the daily lives and activities of these medical volunteers and the community members with whom they interacted, revealing nuanced insights crucial to understanding the full range of ethical and material problems that surround these fleeting forms of care.

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<sup>16</sup> With the exception of my epically wonderful research assistants, whose names I use with their blessing, the names of all individuals and organizations mentioned in this paper have been changed or omitted to maintain anonymity; though, of course, a scholar of the region and anyone who knows me will be privy to the world beyond the pseudonyms. Double quotation marks in the text surround verbatim citations taken from printed text, recorded and transcribed interviews, or from field notes written during or shortly after an interview. Single quotations represent my own paraphrasing.

Walking countless mountain miles—at times chasing, and missing, health camps or food aid helicopters—I found conversations on the trail, in teashops and tiny hotels, and around many hearths. This “movement as method” (Harper 2003: 49) allowed me to speak with people who are normally too busy to be found in clinics or hospitals, and in settings convenient for those who came to medical camps and food aid distribution events from far away. An exhaustive list of individuals with whom I spoke is not possible, but includes village health workers (VHWs), government health workers (GHWs), physicians working in cities and remote district headquarters; local politicians; *bideshi* and Nepali NGO staff; international medical volunteers; development and international aid officials; Maoist officials and cadre; medical college staff and students; passing traders; and Nepali villagers who attend and do not attend health camps or food aid distribution events. I wrote profusely in my journal, never knowing what would be important. I offer photos throughout this dissertation, knowing they are one-dimensional, but also hoping that they offer a glimpse of life in Humla and its many textures, its beauty and sorrows.



**Figure 1.4** My field notes with tiny handwriting, drawings, and newspaper clippings.

I am aware that, in the end, this ethnography is partial, in both senses of the word. And, I am left to ponder how well I tell the stories of those who asked me to do so most, and of those whose

stories I'd like most to tell because of the ways they moved me. Here, I both acknowledge my own limits in ethnographic story telling (Beatty 2010) while also sharing in Scheper-Hughes' exhortation for a "good enough ethnography" (1992: 28), both in spite and as a result of our cultural biases and predilections, with our ears to the ground, listening and observing with compassion. She writes:

Seeing, listening, touching, recording, can be, if done with care and sensitivity, acts of fraternity and sisterhood, acts of solidarity. Above all, they are the work of recognition. Not to look, not to touch, not to record, can be the hostile act, the act of indifference and of turning away (*Ibid*, 28).

Ultimately, the text below is presented as I choose, and my analysis is also a testimony. Therefore, following Mosse's (2005: ix) methodological incorporation of Latour's (2000: 115) notion of objectivity—that is, maximizing opportunities for people to *object to* what is written and said about them—I have shared and discussed this manuscript with many of those whose lives and work are represented here, and I continue to do so. My observations will undoubtedly please some at the cost of angering others. Indeed, they already have. To quote the former director of a NGO who was displeased with a statement I gave to a reporter's question about my participation in organizing health camps in Humla:

In some ways you and the journalist are alike, both middle-class lads journeying to one of the world's remotest and poorest areas, where life for many is not a honeymoon, acting the would-be journalist striving for a scoop and 40 pieces of gold; and you as the liberal do-gooder expert student using whomever or whatever you can find in a vast mountainous classroom to validate or prove "your point" in order to get a better grade.<sup>17</sup>

I do not take these words lightly, for as out of line as I feel they were, they continue to remind me of the public-political nature of engaged ethnography, and that the issues I am writing about here have real world implications.

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<sup>17</sup> The comments of mine published in a *Nepali Times* article to which he is referring to went like this: "Health camps are more like medical circuses, and they obscure the real political and economic origins of sickness; they're a Band-Aid on a festering wound." I have written elsewhere about the conflicting accountabilities and relationship "fallout" that can result from simultaneous participation in and critical examination of NGO work and short-term medical interventions (Citrin 2008). See Mosse (2005, 2006) for excellent discussions on the challenges and ethics of straddling relationships and politics while conducting ethnographic work among international development organizations and other professional communities.

Still, others have suggested that I have omitted the most serious transgressions committed by certain NGOs or at particular health camps. However, indictment is not among the goals of this thesis. Rather, I have chosen to foreground the perceptions and voices of Nepali people with whom I worked and conducted interviews, who plan and attend health camps, and who volunteer their time and skills. Undoubtedly, their words and actions serve as powerful critique and recommendation, and rightly undo the inappropriate binary of help vs. harm. Beyond this, it is my hope that their experiences and knowledges will be brought to bear on the process of creating social justice-oriented policies that address longstanding, unmet basic and health care needs in the region. I see the continued task of a new generation of engaged social scientists to incorporate into ethnographic work the vested—and especially the contested—voices of our “informants” and coworkers. I do so here to more collaboratively unsettle comfortable assumptions surrounding contemporary models of short-term care in “resource-poor” settings.

In the end, I am left personally to contend with Marcus (2010: 357), who suggests that anthropological research in troubled lands or situations of suffering and crisis are increasingly difficult to justify, and may very well stake the integrity of our ethnographic practices. My discomfort with studying and writing about sickness, hunger, and deprivation, I trust, comes through. The fact that so much suffering and hardship is the grist for this thesis makes me deeply sad. So, with the words I have now, I am trying to do good enough. In thinking of the struggles and injustices I have seen, I repeatedly return to the words of Paul Farmer (2003: 224), who writes: “That we can study, rather than endure, these abuses is a reminder that we too are implicated in and benefit from the increasingly global structures that determine, to an important extent, the nature and distribution of assaults on dignity.” Still, I feel all of this renders anthropology no less “the “most fascinating, bizarre, disturbing, and necessary form of witnessing left to us” (Behar 1996: 5). I believe that anthropologists are indeed well positioned to render visible the interconnections between global policies and practices and the suffering and injustices that all too often go unnoticed; or worse, justified in the name of humanitarianism or doing what is “better than nothing.”

## A Walk Through My Chapters

Having laid out the core theoretical frameworks and conceptual tools that inform my study, in chapter two I explore an “Unnatural History of Health and Hunger,” taking a long-view history of the Karnali region, contextualizing the major factors that have brought about widespread changes in livelihood strategies and socio-economic opportunities in the vast mountain periphery of Karnali. These include the region’s colonial history, border and grazing restrictions, the reach of iodized Indian salt into Karnali and the subsequent downfall of the salt-rice circuits, the liberalization of the economy, the reorientation of the Kathmandu-centric government towards *bikās* (“development”), the ensuing explosion of NGOs and humanitarian groups, and a decade-long Maoist “People’s War.” This chapter attempts a ‘historical reading against the grain,’ locating the determinants of sickness and hunger in Humla not in the backwards practices of its residents, but rather in Karnali’s history of neglect and institutionalized underdevelopment, and a changing regional political economy. This chapter sets the stage for understanding how Humla came to be known as such an ‘out of the way place’ with people represented as backwards, poor, sick, and hungry.

Chapter three, “Finding the ‘Hidden Himalayas’: In (Re)Search of Everyday Life in Humla” describes my research site and brings the reader on a brief and partial ethnographic tour of the district. I describe life in Simikot, Humla’s changing mountain town district headquarters, as well as the sights, sounds, and textures of life when people are not seeking out foreign medical volunteers, or walking great distances to wait on lines at health camps and food aid distribution events.

Chapter four, “Examining the Circulations of Short-Term Medical Volunteers in Remote Nepal” examines the social and political lives that surround *bideshi* medical volunteers as they circulate in Humla. I begin by bringing together ethnographic narratives of Shangri-La and early medical missioning to trace the range of motivations and meanings associated with the history of foreigners coming to heal and ‘do good’ in the remote mountains of Nepal. The rest of the chapter offers a close up ethnographic look at the implications of medical volunteers living and practicing medicine in Humla. The stories and reflections offered by medical volunteers and the local health care workers and Nepali villagers with whom they interacted reveal a range of social, material, and medical consequences. At the same time, these experiences of short-term

care challenge the taken-for-granted assumptions of ‘doing good’ abroad while also continue to build on the idea and representation of remote mountainous places as poor but beautiful, and in need of continued foreign medical intervention.

Chapter five, “Health *Camp*lications, and the Social and Political Lives of Medicines,” offers an ethnographic discussion of health camps in Humla. It begins by tracing the emergence and growth in popularity of the medical camp model in South Asia back to family planning programs in India. I discuss how the health camp became a paradigmatic model of short-term intervention in Nepal today, used by NGOs, military cadres, and the state. I explore how health camps occupy socio-political and health(care)-related spaces in remote Nepal today, where a complex universe of global, national, and local worldviews and health belief systems interact. These include those of medical practitioners, governments, NGOs, and “target populations.” I propose that camp attendees must be seen as mindful agents bringing a range of needs and meanings to the camp experience, many of which arise out of the complex landscape of Nepali syncretic healing modalities and the exigencies of life during times of war and in settings of structural violence. I show how the strategies used by camp attendees to stock up on health camp medicines (1) are part of a universe of plural approaches to healing; (2) constitute creative and improvised strategies of everyday life in the context of basic needs, unmet and redefined; and (3) can be construed as intentional acts of de-medicalization that defy and force a rethinking of the subjectivities (representations) ascribed to them as sick, unknowing villagers in desperate need of medical care.

Chapter six, “Unpacking Food Aid Rice: Changing Foodways, Hunger, and the Taste of Temporary Meals in Humla,” builds on the last chapter by looking at the prominence of intermittent food aid programs in Humla, and explores the social, political, and (agri)cultural effects of rice acquired through these programs. I begin by expanding upon chapter two’s discussion of the impact that the influx of cheap, iodized salt from India had on local agropastoral practices and the regional economy—here, I draw on interviews especially with elders. I then turn to discuss food aid distribution events in Humla, where—much like health camps—villagers often walk great distances and wait on police-run lines, hoping to have a basic need met by a humanitarian group that descends periodically in a helicopter. I focus on the Nepal Food Corporation’s (NFC) food depots (Nepali: *godām*) operated throughout the district, and the UN World Food Program’s (WFP) interventions, which were often coordinated by NGOs and largely

centered on either food-for-work (FFW) projects or protracted relief operations both before and during the People's War. Drawing on observations, household survey data, and interviews, I offer an ethnographic reading of the narratives and stories shared by my research participants as they wait in line and work for, unpack, cook, eat, trade, sell, re-distribute, and distill into alcohol food aid rice. I argue that food aid programs fill a need and provide a tenuous safety net for many households in Humla while at the same time, their continuous presence contributes to transformations in household economic practices as well as the values that surround growing, serving, and eating local foods and foods donated to them.

In the concluding chapter (seven), "Dispensing (with) Health and Hunger? Thinking Beyond Short-Term Practices of Care," I retrace the main points of the preceding six chapters and discuss in detail the significance of my findings and central arguments. I also explore concrete ways that these insights might be used to rethink, rework, reform, and reinvent the promises, policies and practice of global health, humanitarian, and development efforts in pursuit of Nepal's elusive health and wellbeing. I discuss some lessons that can be gleaned from short-term medical volunteer programs, health camps, and food aid programs in the context of Humla, and provide some recommendations that may be applicable to other settings where growing assemblages of foreign actors and institutions are concretizing new forms nongovernmental governance in conditions of chronic vulnerability and deprivation.

## CHAPTER TWO

### Tracing an Unnatural History of Health and Hunger in the “Hidden Himalayas”

*What until yesterday was this part of Nepal? A geographical mystery, a disorder of valleys and mountains where a people, whose existence of disappearance left us totally indifferent, struggled against isolation, climate and poverty.*

~ Giuseppe Tucci, *Nepal: The Discovery of the Malla*, 1962

*The government might also consider changing the name Humla, as people often make fun of it. Humla-Jumla has become synonymous with poverty, hunger, and backwardness. We have developed a kind of allergy to this word Humla.*

~ Phuntsok Dorjee, *High Road to China*, 2009

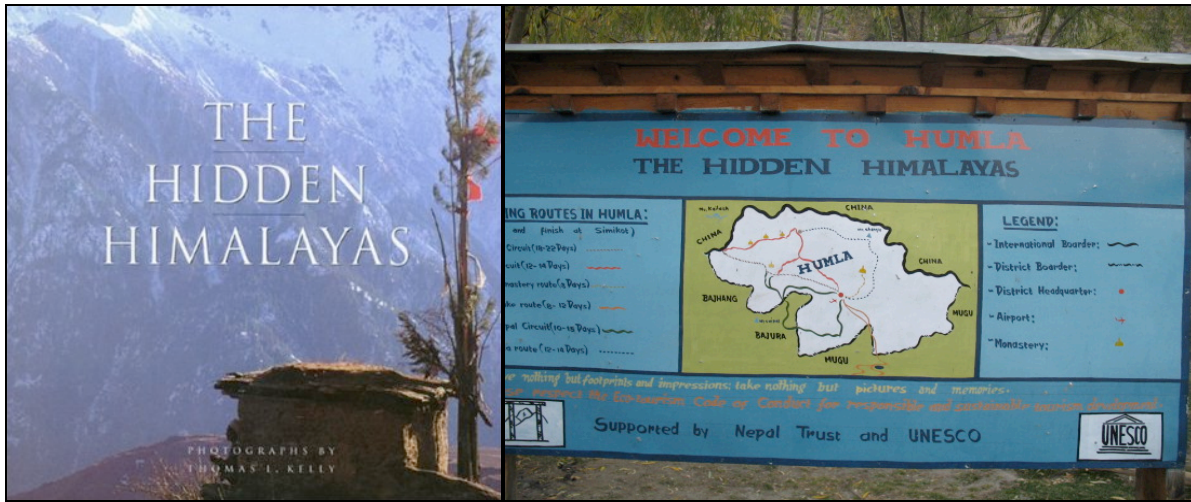
#### An Introduction to an ‘Out of the Way’ Place

‘*Bāphre! Humla-Jumla, kina tyasto biggaT Thāu jāne?*’ (Wow! Humla-Jumla, why are you going to such a remote place?). I encounter this sentiment frequently when I speak in Kathmandu about my research site, Humla, a district in Nepal’s far northwest Karnali Zone. Karnali is a peripheral place in a peripheral country, and it boasts complex socio-cultural and political economic histories. Famous as the home of an ancient Khasa empire and a once-prosperous mountain hub of herding and trade between India and Tibet, in recent decades the Karnali region has come to occupy a prominent place in the imaginations of most Nepalis and onlookers of Nepal as a road-less “*kālapāni*” (Nepali: “black water”) where life is grueling and bleak. The five districts that comprise Karnali’s current administrative zone—Mugu, Dolpa, Kalikot, Jumla, and Humla—rank consistently at or near the bottom of Nepal’s 75 districts on most socio-demographic and health indices, and local media coverage of the region reinforces this representation. Newspapers often show photos of district airstrips closed to snow, and headlines tell of food aid flight cancellations, impending famines, and annual disease epidemics (Figure 6.3). Tsewang “Chakka Bahadur” Lama (2002: 36)—Humla District’s first Member of Parliament—notes that these mistaken portrayals cast the Karnali as “some sort of hell-hole of

Nepal because of the rampant hunger and poverty pervasive in the region.” How did the Karnali, and Humla in particular, come to be known as a place characterized by such high rates of poverty, sickness, and hunger?

This chapter traces an “unnatural” history of health and hunger in Karnali, contextualizing specifically the constellation of factors that have led to drastic changes in livelihood strategies and socio-economic opportunities in Humla, a district that has earned the moniker the “Hidden Himalayas” (Figure 2.1). In doing so, I have two interrelated objectives. Firstly, I situate this discussion of Karnali within recent writings on highland and mountainous peripheries characterized as “non-state spaces” with overlapping ethnolinguistic, socio-cultural, and political economic histories (Scott 2009; Shneiderman 2010; van Schendel 2002). An initial focus on the Karnali region’s political history here is necessary to understand the unique, polyethnic cultural formations and subjectivities that have emerged as the region and its inhabitants underwent processes that transcend fixed nation-state borders. As DesChenes (2007) and Shneiderman (2010) have argued, studies of the Himalayas that take regional political history as a starting point might serve as a much needed correction to the legacy of anthropological writings that focus on discrete, supposedly isolated ethnic groups and villages with little concern for regional state formations or national polities. The story I wish to tell in this chapter, then, is one of regional significance, though it is necessarily part of a much longer national political history. A discussion of the real and represented forms of everyday suffering that characterize life in Karnali region today requires an analysis that is historically deep and geographically broad (Farmer 2003; Scheper-Hughes 1992).

Secondly, this chapter is a ‘reading against the historical grain’ of existing writings and popular representations of the region. Sifting through these narratives, I undertake a synthesis of writing and scholarship on this region to locate the determinants of sickness and hunger in Karnali (and Nepal more broadly) neither in the backwards agro-pastoral and socio-medical practices of its residents, nor in the ‘naturally occurring’ environment of poverty in which most remote villagers find themselves; as it so often seems in representations of the region found in development and humanitarian literature. Rather, the conditions that confine life chances in Karnali are traceable to its histories of feudalism and oppression, and its subsequent state incorporation and institutionalized underdevelopment.



**Figure 2.1** (left) Thomas Kelly and Carroll Dunham’s anthropological photo book, which depicts the seasonal rhythms of Humla; (right) a NGO sign welcoming visitors to the Hidden Himalayas.

In this discussion, I draw on historical literature of the region to engage with an “anthropological Karnali” (DesChenes 2007) so that, in later chapters, I can foreground the voices of my research participants to encourage the telling of what Clifford (1997: 264) calls “counter-histories”— autochthonous, cultural critiques of a linear history. The recognition of complex and contested histories may begin to clear “a space in which the formerly voiceless might begin to articulate their desires—to *counter* the domination of prevailing authoritative discourses” (Moussa and Scapp 1996: 88).<sup>18</sup> This goal is entirely applicable to the political and theoretical project of reorienting unilinear development trajectories and interrogating hegemonic narratives of the ‘chronically sick and food insecure’ residents of Humla. A critical, regional political history, then, is an appropriate departure point if we are to better understand the subjectivities currently ascribed to—and the identities sometimes deployed by—*Karnalivasi* (the people of Karnali) as backwards, rural peasants with high burdens of disease and famines, and desperately in need of (mostly) external humanitarian intervention. However partial, this chapter offers a long-view, historical exploration that seeks to reveal “how out-of-the-way people came to be out of the way in the first place, while radically questioning the civilizational discourse applied to them by their self-described superiors” (Scott 2009: xiii).

<sup>18</sup> This is similar to the Foucauldian articulation of ‘counter-discourse’ proposed by Moussa and Scapp (1996).

## Is Karnali in “Zomia”? Why a Regional Political History of the Hidden Himalayas

In *The Art of Not Being Governed: An Anarchist History of Upland Southeast Asia*, James Scott (2009) builds on Willem van Schendel’s (2002) neologism “Zomia” as a geographical heuristic to explore the “zones of refuge” where highland peoples have historically sought to evade a range of state-making projects, such as taxes, slavery, conscripted labor, disease, and war. Though distinct in innumerable ways, the various peoples who inhabited this expanse shared certain ethno-linguistic, religious, and cultural affinities, as well as ancient trade networks and ecological niches. For Scott, these areas represented “non-state spaces” where communities devised pliant kinship, religious and social structures, oral histories, and agro-pastoral practices best suited to avoid the centrifugal nature of the state while still maintaining the economic advantages of connections with lowland territories.<sup>19</sup> In his view, these “escapist practices” signal the social and historical choices made by communities with the explicit intention of keeping the state at a distance.

Van Schendel’s original conceptualization of Zomia as a geographical region stretched from the highlands of central Vietnam to provinces in China, and it encompassed nearly all of the Himalaya Massif, including Nepal.<sup>20</sup> Yet, Nepal is conspicuously absent from Scott’s discussion of Zomia. He may have simply stuck with the ethnic communities and region he knew best; or, at work here may be what DesChenes (2007: 209) refers to as Nepal’s “condition of non-postcoloniality”—the near outright ‘invisibility of Nepal studies within the larger area studies framework of South Asia studies.’<sup>21</sup> This geo-historical erasure is peculiar not only because the pan-Himalayan zone has long been a place of refuge for a range of diverse

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<sup>19</sup> Of course, these are all different, but the overlapping Tibeto-Burmese vernaculars of highland and mountainous communities in Nepal, for example, often stand out in stark contrast to the Sanskritic dialects that emerged closer to the lowlands and valleys.

<sup>20</sup> In addition to Nepal, Bhutan and parts of the Indian Himalayas were also removed from Scott’s conceptualization of Zomia (Shneiderman 2010: 292). For a map of Zomia as conceived by van Schendel, see (2002; Fig. 2, p. 653). It is clear that Karnali falls well within this space. See the 2010 (Vol. 5) special edition of the *Journal of Global History* dedicated to “Zomia and beyond” for a range of excellent papers. In light of the recent Bush-Obama imperial wars led by the United States, Jacobs (2012) has recently expanded the bounds of Zomia to the mountainous border peripheries of Pakistan and Afghanistan, where citizens there are surely fleeing violent state-making projects waged in the guise of spreading democracy.

<sup>21</sup> I have also experienced this as a student of Nepal; rarely encountering a class specifically taught on Nepal, or the Himalayas [with the exception of one course taught by Jane Dyson]. In the past, I have routinely created a “Nepali” box on language funding applications for South Asia centers, or, even, checked the “Hindi” box, knowing I would later have to finagle some paperwork or obtain an additional signature to use the funding to study Nepali.

populations fleeing invasion and conquest (Zurick 1992), but also because of a well-established regional ethnographic tradition that characterized some early ethnographies of the Himalayas, and of Karnali in particular.

In Sara Shneiderman's (2010) article, "Are the Central Himalayas in Zomia?" she notes how, in many ways, Himalayan studies was "ahead of the curve" in developing an ethnographic tradition that paid careful attention to the shared cultural-religious traditions and livelihood pursuits of ethnic communities that inhabited overlapping agro-ecological zones. Indeed, the idea of Nepal as a Himalayan "interface" of language, cultural-religious forms, and trans-regional agriculture and trade has long shaped analyses of the Himalayan region (DesChenes 2007; Shneiderman 2010). Brian Hodgson's early ethnological work in Tibet, Nepal, and India helped forge an early Himalayan studies (cf. Waterhouse 2004). And, van Schendel (2002: 656) reminds us that Christoph von Furer-Haimendorf was an early "Zomianist" who productively theorized the links between Karnali ethnic groups, kinship, political structures, ecology, and trade patterns that transcended multiple boundaries.<sup>22</sup> Later scholars of the region, such as Rauber (1980), would go on to study the dynamics of ethnic formation in specific historical-economic context, and in direct relation to the political and economic pursuits of other groups.<sup>23</sup>

There are, however, several reasons to be cautious in applying "Zomia-thinking" to an analysis of Karnali. For one, the retrospective designation of new "world areas" is risky business, particularly by privileged academics. The idea of Zomia is no doubt catchy and tempting, much like the recurrent trope of Nepal as a Shangri-La (DesChenes 2007; Michaud 2010), which is a theme I discuss in greater detail in chapter four, and one that lingers throughout the dissertation. But, reductionism is bound to follow an analytic orientation that subsumes under one "ethnonym" the "hundreds of different minority peoples, each with their own names for themselves and their own political projects" (Shneiderman 2010: 311). Shneiderman (*Ibid*, 299) also encountered outright skepticism when she discussed the concept of Zomia with Nepali colleagues and communities, who were predictably weary of anything resembling a geographical

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<sup>22</sup> Of course, Furer-Haimendorf also produced work that was decidedly characteristic of an anthropology that focused on seemingly bounded communities or ethnic groups, famously covering the anthropological "checklist of culture," (Beine 1998: 173), detailing the economic and political systems of the groups, their kinship, religion, arts, marriage and settlement patterns, values, moral customs, rites and rituals with little attention to processes of regional state formation.

<sup>23</sup> Rauber's (1980) study of ethnogenesis among the Humli-Khyampas offers an important analysis of the formation of ethnic groups under specific historical circumstances, and in relation to specific ecological niches of trading, dynamics of intra-cultural identification, and politico-juridical unity under newly ascribed leaderships.

determinism that equates—and, thus, conflates—environmental niches with the complex generative processes that shape broader socio-political and economic forms: “That sounds like the old ecological model” they told her. “Why do we need that?”

Scott (2009: xii), too, has suggested that Zomia thinking may no longer be applicable in the wake of World War II due to the widespread enclosures of these once ungoverned—or, at least, less legible (cf. Scott 1998)—areas, and the subsequent accumulation of their erstwhile residents through the “distance-demolishing” techniques of states: cadastral surveys, roads and railways, aircrafts, phones, computers, and the growth of other information technologies, all of which have been highly effective in reducing the “friction of terrain” that mountain fastness once provided. Warning would-be “Zomianists” of the concept’s contemporary applications, Scott writes that, if his analysis does not apply today, “don’t say I didn’t warn you” (2009: xii).

These essential critiques of Zomia notwithstanding, I’d like to propose along with others (Bonnin and Turner 2012; Shneiderman 2010) that “Zomia-thinking” is still useful in understanding the identities, beliefs, practices, and creative livelihood strategies that populations living in Nepal’s mountain peripheries have long held, and continue to utilize today. A long-view history of Karnali reveals distinctive choices and interactions among its residents that I find characteristic of Zomia: these include the reworking of genealogies, caste, and ethnic identities; the creation of social structures that favor fission and reformulation; livelihood pursuits that have tended to maximize mobility, dispersion, and resistance to appropriation; and plural, syncretic Hindu-Buddhist-shamanic-animist practices and “oracular cults” that have, in many ways, stood as forms of cultural resistance to the encroachment of an increasingly Hinduized Nepali state. There are surely others I have missed.

I do not, however, wish to imply that communities in Humla—nor in other parts of Karnali—have sought to escape the state directly in all forms. This would deny the unheard cries of many—though not all—who aspire to be more connected to Nepal’s emerging socio-political and economic spheres, which are largely represented and legitimized through the idea of *bikās*, or “development” (Mikesell 1999: 71; Pigg 1992, 1996). As Scott (2009: 331) remarks, it is “crucial to understand that what is being evaded is not a relationship per se with the state but an evasion of subject status.” This is a crucial point; for, while Humlis people bemoan the ambiguous presence of NGOs and their projects, they avidly seek out the products and services they provide. Still, Zomia is characterized in many ways by its political marginality, and by a

rather antagonistic relationship with the valley-dominated states (van Schendel 2002: 654). This accurately describes the sentiments of so many residents in Humla with whom I spoke: feelings of being forgotten in the mountains by a centralized government run largely by high-caste Hindus who look down on them because of their poverty.

In my own thinking about Zomia, I am inclined to side with Shneiderman (2010: 290) who notes that, while problematic for both empirical and political reasons, the analytic imperatives that undergird Zomia-thinking are useful for understanding how remote Himalayan communities continue to navigate a complex range of ‘state effects.’ She points to her own long-term research among the Thangmi (Thami), who have historically utilized “Zomian” strategies to remain largely ungoverned in the Himalayas. However, in Nepal’s contemporary arena of contentious identity politics centered on a more ‘ethnically inclusive’ state (Lawoti 2007), the Thangmi and many other ethnic communities are seeking historical reclamation to gain access to new rights vis-à-vis an emergent republic—a *Nayā* (New) *Nepal*—potentially based on ethnic federalism (*samghiyatā*). As such, it is important to follow Shneiderman in expanding the concept of Zomia to respond to the contemporary strategic articulations of identities—ethnic, regional, or otherwise defined—in specific historical contexts, which are often deployed for political reasons. I would suggest that *Karnalivasi* deploy today a regional identity of exclusion—not one of ethnic distinction—with similar intentions. They do so by readily making distinctions between “here” and “there”—where ‘here’ represents the out of the way, remote, impoverished, and resource-limited conditions in which Humli people struggle for livelihood, and the ‘there’ refers to Kathmandu and other western countries from which the growing stream of NGOs and foreigners hail. I hope this will emerge later in the ethnographic grist of later chapters.

As I hope to illustrate throughout this dissertation, the creative strategies of everyday life (cf. Kerkvliet 2009) in Karnali today continue to be shaped by a range of shifting centers of power, though not necessarily those of central governments or nation states. In the case of Humla, I propose that the concept of ‘the state and its effects’ must be expanded to include the contemporary assemblages of “nongovernmental governments” (cf. Fassin 2009; Ferguson and Gupta 2002)—vast numbers of NGOs, humanitarian and development institutions, and medical volunteers from elsewhere—which, in such large number, comprise the late Nepali anthropologist Saubhagya Shah’s “NGOdom” (2002). These organizations constitute the new

centers of power (and ambiguity) that villagers must navigate to find employment, seek health care and obtain medicines, supplement meager or less-than-expected harvests with food aid rice, which are used in a range of ways for a variety of needs. In these material ways, we are again reminded of the ways in which NGOs become another strata of government, which villagers engage cautiously, sometimes cynically, in order to satisfy the basic needs of everyday life in remote Nepal.

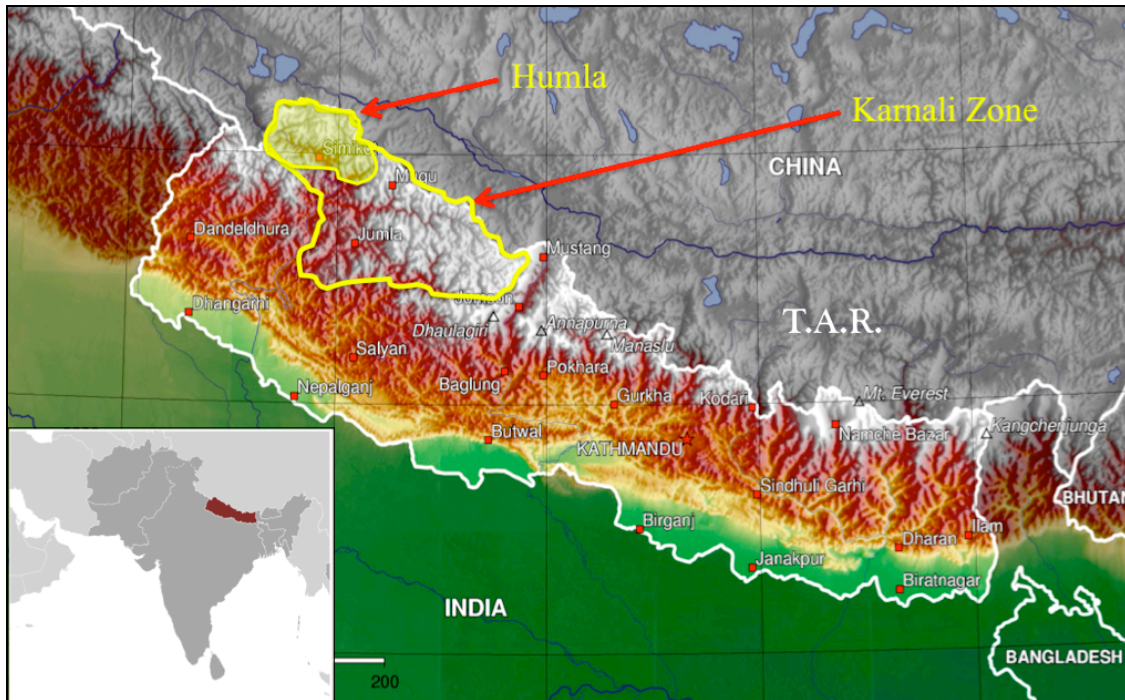
And, perhaps more than in any other recent time, many Humli people employed “escapist practices” to avoid conscription into the Peoples Liberation Army (PLA) and confrontations with the then-Royal Nepali Army (RNA) during the Maoist conflict. They did so for several reasons: to avoid the violence and trauma of direct armed combat, to minimize forcible donations of money, goods, and grain by roving guerilla cadres, and to maximize the “friction of distance” (Scott 2009: 166) between them and those seeking to recruit, modernize, tax, and—we can now add—develop them, especially when the outcomes of these encounters are uncertain or potentially detrimental to livelihoods. At the same time, in some instances villagers in Humla engaged with the Maoist conflict willingly based on household calculations of risk and reward, and availability of human resources to ensure enough food (Sanders, forthcoming). I discuss the Maoist conflict in greater detail in the chapter below.

I hope to avoid reading overly romanticized notions of resistance into the lives of people whose extant realities are shaped by a complex web of socio-cultural, political economic, and ecological processes, as well as by the (sometimes contradictory) choices made in response to those processes. Far from being “hidden,” it seems logical to recognize that, precisely because of its inaccessibility and rugged mountainous terrain, the Karnali Himalayan region has tended to remain a “zone of political and cultural difference” (Scott 2009: 166)—in comparison to what is considered ‘the rest of Nepal’—thrust up by geological and imaginative orogeny, and therefore perhaps in some ways forever out of reach of even the most earnest attempts to understand all that happens there.

### **Revisiting a Particular Ethnohistory of the Karnali Basin River Region**

Situated in the country’s far northwest corner, Nepal’s Karnali Zone extends from the Siwalik mid-hills (1500-4000m) above the low lying Tarai along the Gangetic plains to the upper reaches

of the Saipal massif (7000m), terminating in the border ranges of the Tibetan plateau (Figure 2.2). Centuries of geologic and hydrologic interaction have created a uniquely open inner-mountain basin of gorges, drainage and catchment areas in the Great Himalaya.<sup>24</sup> It is rugged, but open, terrain that lacks the sharp relief of other mountain areas. Barry Bishop (1990) aptly terms the Karnali region “harsh Himalayan habitat.”<sup>25</sup>



**Figure 2.2** Map of Nepal, Karnali Zone, and Humla District

While early historical and archeological records from the Karnali area are scant, much of what is known about the region to the Western world began with the early 20<sup>th</sup> century explorations of the Italian Orientalist Giuseppe Tucci, one of the first *bideshi* (Nepali: “foreigner”) visitors to offer a written, if limited, study and historical genealogy of the region’s early inhabitants (Fürer-Haimendorf 1988 [1975]: 223; Hitchcock 1978: 111). Tucci (1962: 11, 36) writes:

<sup>24</sup> “Himalaya” is a word derived from Sanskrit (Bishop 1990: 21), and *himāl* is the Nepali word used to designate a mountain, or massif, that is covered in snow all year round, no matter the altitude. I have often been corrected in my usage when standing atop 15,000-foot-plus *pahād*, or hills, in Humla.

<sup>25</sup> Barry Bishop’s (1990) impressive tome *Karnali Under Stress: Livelihood Strategies and Seasonal Rhythms in a Changing Himalaya* offers invaluable data and knowledge about the region, and this dissertation is heavily indebted to this work. A member of the first American team to summit Mt. Everest in 1963, Bishop was drawn to the mountains as a scholar and avid outdoorsmen. He was also, in my estimation, an early Zomianist and worked arduously to advance geographical knowledge of the Himalayan region, its people and cultures. Bishop later became the Chief of National Geographic’s Liaison Office.

Temples, ruins, inscriptions and chronicles came suddenly upon me as if for many centuries they had been awaiting the propitious moment to reveal to me the events of an empire which for three centuries had held sway over a country larger than Italy...I ask people where they are and they might as well have fallen from the clouds. No one has ever heard of them...These villages which seem to be without history become once more a part of a tradition whose memory has been resurrected by our discoveries. Now they are returning to life...An empire was reborn before our eyes (*Ibid*, 60).

Eric Wolf's sardonic notion of a 'people without history' is a fiction given animation by the early ethnographic encounters of remote Himalayan regions such as this one. As DesChenes (2007: 212; see also Onta 1997) asserts, the idea of Nepal as a "fossil state"—a land cutoff, preserved and unchanged from its original form—rests firmly on a "deep-seated presumption that if Westerners were not present and active in a place then history could not really be occurring." The Orientalist themes of pioneering discovery, of opening, knowing, and revealing a *terra incognita*, is one of several descriptive tropes constant throughout the writings of early *bideshi* visitors to Nepal—a theme discussed in greater detail in chapter four.

Much of the historical-archeological evidence and sequencing of Karnali and its residents are, in the words of Tucci, "suspended in the void of chronological uncertainty, glimpses of mythology, and echoes of old Indian tradition" (1962: 60).<sup>26</sup> However, subsequent analyses of the region undertaken by Nepali and Indian scholars offer more in-depth, historically emic perspectives of the region and its inhabitants (Naraharinath's *Itihās Prakāsh Mandal* 1955-56; P. R. Sharma 1971a, 1971b, 1983; Srivastava 1966).

A longer version of this chapter discusses the complex caste and polyethnic formations, the larger political economic changes, and the grassroots religious movements that occurred in the Karnali region as a vast empire of Hindu, Indo-Aryan speaking "tribes" broadly referred to as the Khasa<sup>27</sup> entered the area and slowly extended their rule. By the 14th century CE, the Khasa ruled as far as the Trisuli river in central Nepal, into parts of what are now Kumaon and Garwhal in India to the west, reaching up to the holy Mt. Kailās in Tibet to the north, and perhaps parts of

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<sup>26</sup> Though, of course, all errors contained herein are mine alone.

<sup>27</sup> According to Lama (2002: 8), Khasa means 'those from tropical areas,' with alternative spellings that include Khas, Khasa, Khasha, Khasiya, and Khasira (Berreman 1972 [1963]: 15). The legacy of this name may also be traceable to such places such as Kashmir and Kashgar in Chitral, Pakistan (Atkinson 1886: 375-378; Grierson 1927: 2-8, as cited in Hitchcock 1978: 113).

what is now Ladakh (Berreman 1963: 15-20; Bishop 1990; Fürer-Haimendorf 1988 [1975]: 223; Tucci 1962: 60). However, an in-depth, (re-)reading of regional ethnic formation is not in my ambit here. Rather, it suits us now to jump ahead to the period after the great Malla *Khasadesa* (Nepali: ‘Land of Khasa’) disintegrated into 22 hill kingdoms, commonly referred to as the *bāisi* (the number 22 in Nepali), which were then incorporated into the larger nation state boundaries of the Himalayan Kingdom of Nepal.

### **Karnali Incorporated: A Legacy of Internal Colonialism under “Unification”**

In the 1770s, Nepal was “unified” by conquering armies from the Gorkha<sup>28</sup> region of what is now central Nepal, and the Karnali region was brought within the current nation-state boundaries. At least up until the invasion of these armies, socio-cultural and political-economic developments in Karnali were more closely linked to Tibetan chiefdoms and the happenings in places such as Garhwal and Kumaon than in the valley of Kathmandu (Bishop 1990: 68). For residents of the region, the coming of the House of Gorkha would signal further dramatic shifts in the ‘order of things.’

In the mid 16<sup>th</sup> century CE, an ambitious line of Rajput immigrants who had adopted the honorific “Shah” from the Mughul emperor of Delhi began to expand their princely territory, which was centered in the hills east of the valley of Pokhara in Nepal. At the young age of twenty, a charismatic and ambitious Prithvi Narayan Shah ascended the throne and—with an army marshaled through promises of land grants from newly acquired territory—would go on to conquer all of the principalities ranging from east of the Marsyangdi River north of the Seti basin between Tibet and India and as far as Sikkim. The seats of power in Jumla fell rather easily, though “it took another year of hard fighting to wipe out organized resistance in the northern reaches of Mugu and Humla” (Bishop 1990: 129, citing Stiller 1975: 129).

Prize among these newly acquired territories was the valley of Kathmandu, to where the

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<sup>28</sup> There is a need to distinguish between “Gorkha,” the location and name of the Shah Dynasty line, and “Gurkha,” which is a misspelling of Gorkha and applied broadly to the troops that were historically hired by the East India Company to fight in their wars. Gurkhali is also a word that was used to refer to the Nepali language by urkha troppos. Among the “Gurkhali” included a range of ethnic groups, most famously the Rai, Magar, Limbu, and Gurung.

seat of power was moved from Gorkha.<sup>29</sup> The Shah dynasty's conquests were part of a wider pattern of state formation underway in Asia, and successors of Prithvi Narayan continued this expansion until, by 1808, the newly formed Kingdom of Nepal had reached its largest size, stretching more than 2,000 kilometers between the Sutlej River in current Himachal Pradesh and the Tista River in Darjeeling. Border disputes were unavoidable among emerging regional powers, such as the East India Company (EIC) whose imperial expansionist projects in neighboring Bengal were already underway. China, too, had recently captured Sinkiang (Xinjiang) and assumed a "protectorate" role over its Tibetan vassals. In subsequent decades, Nepal's physical borders would change a number of times as a result of conflicts between these powers. The Chinese began to advance towards Nuwakot, home of the Gorkhalis. Both Beijing and Kathmandu had sent requests to the British for help with mediation, but by the time the East India Company dispatched Colonel William Kirkpatrick, Nepal had already capitulated back to China previously taken land in Tibet, and the impending battle was avoided.<sup>30</sup>

The British never managed to take over Nepal, owing in part to the *kukhari*-wielding Gurkhalis who drove the East India Company back multiple times (Whelpton 2005: 42). The formidable geo-topography of the Himalayas coupled with the "unwholesome vapours" (Kirkpatrick 1996 [1811]: 26) of the malaria ridden Tarai plains to the south offered Nepal further protection. However, in 1815 the East India Company's General Ochterloney—who had already begun recruiting Gorkhali deserters—came perilously close to the valley. This encroachment forced the Nepali rulers to cede back lands to the east and west of its current territories, as well as accept a British Resident as part of the Sagauli Treaty of 1816 signed between the EIC and Nepal's rulers. Nepal's most famous resident and a pioneer of Himalayan

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<sup>29</sup> The Italian Capuchin monk, Father Giuseppe di Rovato (1970 [1790]) details Prithvi Narayan Shah's descent into the valley and the final years of Nepal's "unification" from the town of Patan. He describes the lurid scenes from the final capture of Kirtipur where Prithvi had "issued an order...to put to death all the principal inhabitants of the town, and to cut off the noses and lips of everyone, even infants, who were not found in the arms of their mothers." (1970 [1790]: 15).

<sup>30</sup> Still, Kirkpatrick remained in Nepal for approximately seven weeks and, upon his return, wrote a massive travelogue, which was the first full account of the country to reach Western eyes (Beine 1998: 164). Allen (1994: v) suggests that Kirkpatrick's tome, titled *An Account of the Kingdom of Nepal Being the Substance of Observations Made During A Mission to that Country in the Year 1793*, marks the "fitful" beginning to the anthropology of Nepal, providing "bright insights into the nature and structure of Nepalese society and culture, and in doing so provided the nucleus for the coming generations of anthropologists." In this volume, with clear strategic intent, Kirkpatrick meticulously described and sketched the routes he traversed and distances between points; life patterns of the peasantry; agricultural and commerce systems; tribal variation; language and alphabet; flora and fauna; and form of government, its revenue, and military establishments. This work also reveals many of the colonial and Orientalist tropes that we find recurring throughout the subsequent works of this period and later on, beginning with the putative "discovery" of an unknown land, a genuine *terra incognita* (Kirkpatrick 1996 [1811]: 1).

ethnography, Brian Hodgson, took over at the end of 1832 (Waterhouse 2004), and as part of the treaty, Nepal was also required to allow continued recruitment within the country for its growing Gurkha army.

These events were instructive to Prithvi Narayan Shah who—in the *Dibya Upadesh*, his political testament dictated a few months before his death in 1775—famously described his recently conquered kingdom as “a yam between two boulders” (Whelpton 2005: 37). He was firm in his recommendation that, when he was gone, his territory must continue to assume a strong defensive position against China and the British Raj, a dictum that would come to play an important role in later geo-political developments for Nepal.

P. R. Sharma (2004: 222) has suggested that King Prithvi Narayan Shah’s conquest helped to integrate a diverse land, facilitating the evolution of “a respectable, civilized polity in an area where fragmented tribalism alone would have otherwise prevailed.” It is a fact of history, he notes—an “unsavory” one, but a fact nonetheless.<sup>31</sup> For Karnali, this incorporation initiated 200 years of internal colonization, where the region was treated as a feudal state and its inhabitants excluded from emerging socio-political and economic spheres (Adhikari 2008). To return to Bishop’s (1990: 126) clear synopsis:

In less than a century, the House of Gorkha had unified militarily or politically a panoply of medieval principalities and tribal territories whose societies reflected the spectrum of Himalayan traditions—Hindu, Buddhist, Khasa, Magar, Gurung, Newar, Kirati, and even Islamic. However, integration into a modern nation-state of these diverse cultural regions...did not follow. Instead, a combination of environmental, economic, social, and political factors from international to local level permitted new or continued exploitation of the bulk of the peoples by a privileged few and elite (sic).

Rather than return to, or leave in place, historical social forms and political economic practices that allowed some internal growth and development in Karnali, the government “continued to follow the retrogressive course of feeding feudal appetites by rigorously milking its provinces of whatever wealth they would yield” (Bishop 1990: 139). The new government worked through Karnali’s existing feudal structure to centralize authority in Kathmandu and to render the lives and livelihoods of those living there more legible; that is, more amenable to state scrutiny,

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<sup>31</sup> For discussions of the formation of the modern political and economic institutions in Nepal, see Chauhan (1971), Jain (1972), Joshi and Rose (1966), S. Kumar (1967), and D. R. Regmi (1950).

control, and taxation (Scott 1998.) Existing labor, land tenure, trade, and tax laws were intensified, creating a new order that was much more repressive than the old. Karnali uprisings like the one mentioned in Humla and Mugu became frequent occurrences, and are part of a long but largely undocumented history of uprisings and revolts against the autocratic rulers of Nepal (Karki and Seddon 2003: 3).

Kathmandu's rulers saw the eventual need to post contingent armies in the region to quell such revolts, leading to an increased need to generate tax revenue (Adhikari 2008: 61). This is significant for two reasons that I will return to in chapter six. One has to do with the fact that rice was the staple diet for those who came from Kathmandu, the centers of military and cultural-religious power. The second point of import here is that the phrase *gorkhe lauri*, which refers historically to the sticks these Gorkha soldiers used to administer physical punishment, is still a common phrase in Karnali used to talk about beatings by police and army.

To generate this revenue, new contractual systems of taxes were levied on livelihood strategies at the village and household level, such as those on the use of grazing pastures, the collection of *jaDibuti* (medicinal herbs, roots, flowers and plants), the production of milk products, the use of water mills, and the sale of salt, wool, falcons, horses, honey, musk and other livelihood products (Adhikari 1988). Other regulations dictated “just where, when, how often and with whom, families, villages, or *dāras* [a newly introduced feudal administrative unit] could graze animals, hunt, exploit the wild biota or trade” (Bishop 1990: 137). Formerly “clean caste” ethnic groups were stripped of their pure status to lower them to within varying levels of tax-paying landholder, cultivator, or tenant. *Birta* and other land grants were taken away, and a compulsory labor system (*jhārā*) was promulgated for all adult males, even Brahmans (*Ibid*, 129-132; cf. Regmi 1971: 104). Still, the bulk of Karnali residents were cultivator-tenants and landless peasants who bore the heaviest burden of the labor obligations, which included,

work in quarries and copper mines, construction and maintenance of trails, bridges, buildings, and fortifications...service as mail runners and porters to carry military supplies, sick persons, tax revenues, luxury goods for the court, and the loads of traveling royalty (Bishop 1990: 129).

Along with these newly legislated forms of economic enclosure and mandatory work roles, the fluid social institutions and norms that had contributed to the polyethnic fabric of Karnali were eroded by new sets of juridical fines for *dharma* violations intended to entrench and enforce

Hindu orthodoxy. These included punishments for abortion, non-sanctioned (cross-class or caste) marriage, and “cow-slaughter.” Bishop (1990: 136) notes that those who intentionally killed a cow were beheaded or enslaved, while those who did so ‘in ignorance’ were fined. This rule, he suggests, was likely targeting the *dum* and other so-called “untouchable” casts, as it did not apply to the killing and eating of yak practiced widely by Tibetan ethnic groups throughout Nepal (cf. M. C. Regmi 1969).

Yet, despite intensive taxation and state oppression, the region remained a major hub of an ancient salt circuit that used large herds of sheep and goats to trade, among other items, Tibetan rock salt for rice and other grains grown in southern Nepal and India (chapter six). Interwoven into the complex arrangement of seasonal livelihood pursuits within and between varying agro-ecological zones, this trade also afforded the mobility to acquire other commodities and foodstuffs not found nearby or grown in insufficient amounts, such as iron, spices, tea, tobacco, sugar, cooking oils, clothing, food grains, and wool. These movements also fostered and formalized important, symbiotic social relations of both fictive kinship networks and marriage ties that spanned great distances.<sup>32</sup> These great agro-pastoral and trans-Himalayan trading traditions of Karnali—and other areas included in the Himalayan Massif—were the focus of studies undertaken most famously by Christoph von Fürer-Haimendorf (1975, 1978), and later by Barry Bishop (1990), Hanna Rauber (1980, 1987), James Fisher (1987), and Kenneth Bauer (2004).

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<sup>32</sup> See Bishop (1990: 291), Campbell (1978: 92-94), and Fisher (1987: 90-91) for discussions of these *mit* and *ista* relationships; the former representing a “blood brother” type of fictive kinship, while the latter refers to casual friendships that, while more easily terminated, still held significance in establishing preferential trading relationships between families that differed in caste, class, and ethnicity. Similarly, wedlock between groups were arranged to facilitate trade and movement throughout the region. Bishop’s survey indicates that Bhotiya and *dum* groups more regularly married within two days away, while the Thakuri spread out further both in search of “ruling Rajput” lineages and distant contacts to provide the “support and succor” to traverse the lengths of the zone (Bishop 1990: 291).



**Figure 2.3** Sheep carrying salt along Karnali’s “pack animal highway.” Bishop (1971), “Roadless Wonder of Western Nepal,” *National Geographic*.

While Karnali is devoid of local sources of salt—a mineral that all plants and animals need to survive—Tibetan rock salt was readily obtained from draining lakes in the plateau east of Lake Manasarowar and Mt. Kailās. I again quote Bishop’s (1990: 300) excellent synthesis here to underscore the importance of these trade and migration circuits:

In Western Nepal, the patterns and processes by which this indispensable commodity [salt], along with wool, animals, and other goods of Tibetan and Chinese origin, flowed southward, and by which equally indispensable grains, as well as other items of Nepalese or Indian origin, flowed northward, were well established by the twelfth century when the western Malla kingdom controlled trade routes through the Himalaya...The most important routes were those that led to the trading *entrepôt* of Taklakot [Purang], especially those that followed the Humla Karnali Valley...

Grains continued to be markedly more valuable than salt in Tibet and the northern reaches of Karnali, while salt remained significantly more dear than grain in the predominantly agricultural regions of southern Karnali and the lower (outer) hills. By engaging in one or more linkages or stages in the Nepalese grain-Tibetan salt exchange during the course of the year, both Pahari and Bhotia, along with Drogra

(pastoral nomads) and other Tibetans, were able to turn a profit that enabled them to satisfy their salt requirements and eliminate their food-grain deficit. Thus the transfer of these commodities triggered, and continued to trigger, all trade in the subsistence economy of the Karnali Zone. Indeed, it constitutes the cornerstone on which the other trading activities hinge (sic).

Over time, the loss of this vital livelihood practice triggered a major decline in animal husbandry, a loss of important social relationships, and an end to the grain-salt-rice trade that historically sustained Karnali residents. This inter-causal relationship must be emphasized, and I will discuss at length in chapter six the transition ‘from grain trade to food aid’ that occurred in Karnali as a result of—along with other factors—the “incursion of Indian salt” into Nepal’s mid-hills and mountains (Bauer 2004: 124; see also Rauber-Schweizer 1987: 346). However, prior to this, in good years the Karnali region experienced a food surplus that sustained residents and their social relationships, despite short growing seasons, poor soil, unpredictable climatic extremes, and steep and rugged terrain. While life in Karnali has long been difficult, people have proven resilient, finding ways to ‘thrive in the spaces in between’ (Bauer 2004: 125).

### **Stagnation in Karnali Under the Reign of the Rana**

Meanwhile, in Kathmandu, another self-named ruling Khasa family with no relation to the Malla—the Rana oligarchy—had captured power from the Shah kings in a violent coup that, in retrospect, eerily foreshadows the ‘who dunnit’ Narayanhiti Palace massacre of June 2001. On a fateful night in 1846, a young Jang Bahadur Kunwar orchestrated a violent *coup d’état* that eliminated all of his political rivals (mostly family members and followers), and initiated a 104-year hereditary despotism of regent kings and queens who were either underage, inept, insane, or all three (Thapa 2005: 59). As a result of years of strategic intermarriage between the two families, internal political struggles became familial struggles, most of which ended in acts of regicide, patricide, fratricide, homicide, or suicide—a trend that highlights how, in part, political violence, corruption, and bloodshed with impunity became normalized in Nepal.

The Shahs and the Ranas—the latter sometimes referred to as a monarchy within a monarchy (*Ibid*, 70)—both followed, to an extent, King Prithvi Narayan Shah’s policy of

“isolationism,” forbidding access to Nepal by most outsiders until 1951.<sup>33</sup> They also contended with emergent regional geo-politics along the Indo-Tibetan frontier between the British Raj and the Qing Dynasty, at times making their own forays into Tibetan territory to seize lands (Bauer 2004: 68).

Within the Hindu Kingdom of Nepal, the Rana furthered aggressive attempts at Sanskritization and forced incorporation of hundreds of plains and highland ethnic communities based on an orthodox Hindu framework (S. Sharma 2002: 25).<sup>34</sup> The Ranas also continued to view Karnali as a vassal territory, and sought to maintain the flow of revenue through an administrative system known as *thek-thiti*, which, among other effects, increased land seizures and contractual taxes. It also placed restrictions on free movement throughout the region to curb outmigration and limit livelihood pursuits dependent on mobility and dispersion (see Adhikari 2008: 62-64).

Apart from this, the Ranas otherwise ignored Karnali, further entrenching economic stagnation and a declining quality of life in the region. The Rana administrators who were sent out to oversee the *thek-thiti* system from Kathmandu subjected Karnali residents to further dehumanizing acts. Oral histories collected by Adhikari (2008: 67) recount some lurid instances of subjugation, such as having to wait on all fours, tied to a tree, with a stone on one’s back in order to present to a local ruler a written request on paper dangling from one’s lips. “There would be a line of people in this position,” Adhikari (*Ibid*, 67) writes. “The idea was that people should think and behave like animals in the presence of...the Ranas.” Though in an extreme form, what Adhikari depicts here is the system of subservience and deference known as *chakari*. Bista (1991: 5) writes that *chakari* is “an essential concept which means to wait upon, to serve, to appease, or to seek favour from a god,” and it has been firmly entrenched as a social institution adapted into secular life from this ritual Hindu practice of obeisance (1991: 89). These

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<sup>33</sup> I discuss this misnomer of strict isolationism in greater depth in chapter four by drawing on Liechty (1997: 7; see also 2003: 153) who productively applies the work of Helms’ (1988) ethnographic examination of power, knowledge, and geographic distance to show how the Nepali elite actually employed a policy of “selective exclusion,” as opposed to one of strict isolationism. As the country entered into larger regional political, economic, and cultural arenas, Nepal’s rulers strove to balance the threat of invasion by the neighboring East India Company while simultaneously attempting to harness their material, technological, and ideological power—that is, the “power of foreignness.”

<sup>34</sup> The *Muluki Ain* of 1854 was an exacting legal code, sought to integrate all linguistic and ethnic groups and existing castes into one overarching socio-moral, religious and cosmological hierarchy. This caste system was law until 1962 when it was declared illegal (Sever 1993: 86; see also Höfer 1979), though many Nepalis still adhere to its system of stratification, admittedly or otherwise.

enduring social configurations—so crucial to understanding the ways that people seek out and obtain things like medicine and food aid—are widely accepted, and have seeped into most bureaucratic, administrative, governmental, and nongovernmental institutions and channels. Along with *chakari*, one can apply corresponding terms such as *āphno mānchhe*, or having and accessing one’s “own people” (friends, family, and other contacts) in positions and circles of influence or power; *nātabād*, favoring family members; and *kripabād*, “a Sanskrit neologism corresponding to the Western concept of favoritism” (Adams 1998: 48).<sup>35</sup> The Ranas and Shah Kings epitomized this meeting of secular and religious patrimony, as they were possessing of a privileged, if sometimes fabricated, affinal relationship to the Hindu gods.

Bishop (1990: 139) records a common *ukān* (proverb) from Jumla that bespeaks the legacy of the Rana regime: *Rāja lāgyo kāl lāgyo*: “If the king [government/state] is after you, death is also after you.” To be sure, many Karnali residents fled these oppressive conditions in search of new lands and livelihoods. And, in a strategic reading of counter-histories revealed to him through interviews, Adhikari (2008: 65) describes how Karnali residents also resorted to practices such as not maintaining trails, and defecating along paths leading to villages to make settlements uninviting to state officials. It is tempting, here, to apply Scott’s (2009) argument that keeping the state at a distance has, for a long time, been a part of the art of not being governed in the mountains. Nevertheless, over time, the cumulative effect of life under the House of Gorkha and Rana alike was a slow erosion of economic self-sufficiency, leaving the majority of Karnali residents in a downward cycle of privation, insecurity, indebtedness, and, in some cases, various forms of servitude. These confluent factors led to a decline in overall agricultural activity and a marked increase in the number of farming families who could achieve no more than a bare subsistence of living through working for others (Bishop 1990: 129-139).

While existing data on demographic processes and population trends at work in Karnali during this time are scant, historically, population health and mortality responses reflect varying traditions of social organization, resource distribution, and household ability to respond to short-term economic stress (Bengtsson, Campbell, Lee, *et al.* 2004). These capabilities were greatly diminished under the Rana regime. Regressive policies of taxation, forced labor, and grain accumulation continued to reduce the overall level of nutritional intake for those most in need—

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<sup>35</sup> Dor Bahadur Bista’s (1991) *Fatalism and Development* is perhaps the best discussion of the origins and applications of these concepts. See also Justice (1986: 43-44, 83, 90), Weiner (1989), and Levitt (1999) for discussions of these various forms of ‘source-force’ as they apply to international aid and Nepal’s health care sector.

small cultivators, pastoralists, and traders. This made them more vulnerable to famine during times of drought, and more susceptible to common ailments still capable of wiping out entire villages (malaria, dysentery, tuberculosis, measles, etc.), as in the case of a cholera epidemic in Jumla in 1894 (R. Devkota *v.s.* 2027, cited in Adhikari 2008: 69) and the influenza pandemic that traveled from India up to the Karnali via trade routes in 1918 (Davis 1951: 41, as cited in Bishop 1990: 146). In addition, the few curative services available at the time were concentrated in urban areas, and few efforts were made to address the health and wellbeing of Nepali people outside the elite, royal or noble, and so there were no institutionalized medical services. Access to the very limited existing health care facilities—all of which were concentrated in Kathmandu—was based on *āphno mānchhe* and the sparse largesse of the Ranas (Dixit 1995; Sigdel 1998) (I discuss the formation of Nepal’s health sector further below).

Famines now combined with population growth<sup>36</sup> and density in villages, which contributed to the spread of disease, and epidemics become more regular in Karnali. The interlocking of micro- and macroparasitism described above led to high rates of mortality that offset population growth in the region, which had already been dramatically reduced during the fighting over Karnali’s annexation. Bishop (1990: 146; Adhikari 2008: 68) estimates that the population of Jumla might have dropped from roughly 130,000 at the time of the Gorkha invasion to around 70,000 in 1870; a reduction of 40 percent in less than one century. Population reached pre-annexation levels around 1940 in Karnali (at least, in Jumla, for which data are available), at which point its rate of growth began to resemble demographic transitions occurring in the rest of Nepal, other parts of South Asia, and the soon-to-be-dubbed developing world. This growth also led to the reclamation of once abandoned land, with the amount of registered land (*khet*) under cultivation increasing by 26 percent from 1868 to 1889. This was most likely done with conscripted Karnali labor input to increase grain yields and taxes. Forests, pastures, and remote farmland were also reclaimed during this gradual period of population and settlement

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<sup>36</sup> Population growth is so often discussed as the major factor that degrades or exhausts scarce resources, upsets delicate ecosystems, and threatens livelihoods. Ives and Messerli’s (1989) *The Himalayan Dilemma* corrects this lack by paying attention to the relationships between local and regional political economy, hierarchies in caste and gender in particular villages, systems of land tenure and taxation. Further, they include an analysis of regional food deficits and the consequent negative effects of external food aid, such as corruption, internal distribution problems, declines in subsistent, self-reliant agriculture, and a decline in maternal and child health (Ibid, 155, 210). The authors also disabuse the scapegoat myth of the ‘ignorant and overly fecund hill farmer,’ which has long retained explanatory dominance in studies of Himalayan environmental degradation (Ibid, 6, 147, 209; see also Macfarlane 1976; Campbell 1979).

recovery, though the lives of most *Karnalivasi* remained entrenched in further hardship as widespread undernourishment and intermittent famine became permanent features of life.

Thus, what begins to take shape is a longer historical view of a region that has undergone a process of what the Nepali sociologist Chaitanya Mishra (2007: 340) has called “peripheralization,” which is indicative of regional and locally-specific process of Hinduization and state formation in Nepal, as well as broader global forces developing at the same time.

### **Geopolitics, and the Consequences of Uneven Development at the Center and Periphery**

The mid-twentieth century was a period of vast nation building in Asia, and life in Kathmandu—by the 1930s known as The Kingdom of Nepal—became more involved in and influenced by regional and global political changes.<sup>37</sup> The ideological and political effects of World War II rippled through Central and South Asia, and for Nepal’s rulers in Kathmandu, a historical balancing act—quite similar to the one envisioned by Prithvi Narayan Shah—continued. To preserve the country’s independence, Nepal’s rulers ‘strategy for survival’ sought to balance and encourage competition between China and India while also hedging the geopolitical ambitions—couched in the language of development (*bikās*)—of many eager-to-intervene nations (Rose 1971; Dixit 1997: 173).

In neighboring India, a number of changes including Mahatma Gandhi’s nationalist movement, the emergence of formalized political parties, and the subsequent withdrawal from the subcontinent in 1947 by the British foretold trouble for the Ranas (Bishop 1990: 147),<sup>38</sup> as did the anything-but-peaceful liberation of Tibet by the Chinese in 1951. Pockets of resistance remained along the Sino-Nepal border, and insurrections were launched from inside Nepal’s borders until the Tibetan Uprising in 1959 (Adhikari 2008: 73).<sup>39</sup> Quelling these uprisings was

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<sup>37</sup> For more complete discussions of Nepal’s emerging state polity and its entrance into broader global arenas at the time, see Joshi and Rose (1966), Mihaly (1965), Mishra (2007), Rose (1971), and Whelpton (2005).

<sup>38</sup> This was especially true because these despots had, at various times, assisted the East India Company in quelling uprisings at least since the rule of Jang Bahadur Rana, and had also become dependent on their protection to maintain their largely isolationist policies.

<sup>39</sup> His Holiness the Fourteenth Dalai Lama left Tibet in 1959 after the unsuccessful uprising to lead a government in exile in India, exacerbating Sino-Indian relations. Many Tibetans also fled at the time, passing the holy Mt. Kailās one last time before entering Karnali. Many sold their familial wealth in the form of animals or sacred Buddhist statues, which generated a good deal of wealth for the Tibetan communities in places like Limi Valley, and other villages leading along the Karnali River to Simikot, Humla’s district headquarters. Many families have had to sell

part of a simultaneous process of Han nation building (Lattimore 1962) along with an attempt to civilize the ‘pastoral barbarians’ of the frontiers to their Confucian ideals (Bauer 2004: 74). Seeking, then, to fasten up its peripheral areas, China did a number of things: they initiated ambitious road-building efforts throughout the Tibetan Autonomous Region (T.A.R.), effectively negotiated away the extraterritorial status of Nepalis (now ‘citizens’) living in the peripheral mountainous regions, and implemented restrictions on the movement of people, animals, and goods across its increasingly fortified borders. For Karnali residents and other communities living on the Nepal-Tibet border whose livelihoods depended on this manifold system of transhumance, trade, and travel, these changes portended hard times in the region.

These occurrences also foretold the impending end to the Rana regime, which was now under continued pressure from Nehru’s Congress party in India to implement democratic reforms throughout the country.<sup>40</sup> In 1950, with the help of the titular King Tribhuvan Bir Bikram Shah—direct descendent from the House of Gorkha—joined forces with the nascent, outlawed and exiled Nepali political parties living in India, and initiated an armed revolt to topple the Rana oligarchy. Nepal’s initial experiment with multiparty democracy—which would last just ten years—began thenceforth. As a result, a number of administrative, and politico-juridical reforms were implemented throughout the country that had both positive and negative implications, felt to varying degrees, for Nepal’s remote regions.

A newly formed Nepali Congress-Rana coalition was formed in 1951, and the next decade was one beset by chronic and muddled political instability (Bishop 1990: 149; Whelpton 2005: 87-99). After much jostling and stalling, national elections in 1959 were held. Eighteen months later, King Mahendra threw the incumbent Nepali Congress Prime Minister in jail, outlawed political parties again, and instituted a party-less *pānchayāt* system aimed at consolidating and centralizing power, though maintaining the appearance of a modicum of village independence.<sup>41</sup>

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these relics during hard times, and it is not uncommon to hear of statues being stolen from some of the ancient monasteries in Humla.

<sup>40</sup> Independent India’s newly formed government, led by Jawaharlal Nehru, had clear historical interests in new relations of economic assistance with Nepal. Nehru, too, was involved in a balancing act—one of appeasing both national and liberal ideas concerning international relations. This is apparent in looking at a speech given during the 1950 Nepali revolution, where he is quoted as saying: “Frankly we do not like and shall not brook any foreign interference in Nepal. We recognize Nepal as an independent country and wish her well. But even a child knows that one cannot go to Nepal without passing through India” (Mihaly 1965: 42).

<sup>41</sup> In 1962, King Mahendra promulgated a new constitution in which sovereignty was returned to the royal family. Arguing that parliamentary democracy was alien to the Nepalese tradition of Hindu monarchy, he assumed emergency powers, dismissed the incumbent Nepali Congress government, and banned all political parties. The

Some reforms were implemented with the (on-paper) aim of improving the lives of some small cultivators, tenants, and occupational castes.<sup>42</sup> Summing up the impact of these changes and machinations for the people of Karnali, one report (KIRDAC 2005: 22, as cited in Adhikari 2008: 73) notes that

The autocratic *Pānchayāt* regime would not alter the deeply rooted practice of exploitation over the resources and population of Karnali. A culture of ‘serving the higher-ups and suppressing the have-nots’ became the self-imposed style of governing paradigm of the local rulers, who were subordinate to the central rulers of Kathmandu...The relationship, therefore, between the rulers and the ruled, persisted like the relationship between colonizers and the colonized. Consequently there was a sense of bitter disappointment among the locals as the rules dispatched from Singha Durbar [Kathmandu] saw themselves as masters and the people of Karnali as their subjects.

In this time, Nepal also joined the United Nations, constructed an international airport, and ended the policy of “selective exclusion” (Liechty 1997) that had come to characterize international relations outside the Hindu Kingdom of Nepal. His Majesty’s Government of Nepal officially “opened” the country to the outside world, and turned to the idea of Development, or *bikās*, as the official rallying cry of the state (N. R. Shrestha 1993: 9).<sup>43</sup> Bista (1991: 133) writes that, with

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*pānchayāt* system was put in its place. The ‘*pānchayātocracy*’ (Gellner 2007: 10) was a political system that elected administrative councils (of ‘peasants,’ ‘farmers,’ ‘youth,’ etc.) indirectly at the village level, but these purely advisory assemblies did little to influence politics on a larger scale, and were seen largely as an extension of the crown and the processes of nation building (Burghart 1993: 1)

<sup>42</sup> One of the administrative reforms implemented after Mahendra’s bloodless coup in 1962 was the reordering of Nepal’s territory into 75 administrative districts and 14 zones. The Karnali Zone only then officially included the five current districts—Humla, Mugu, Jumla, Dolpa, and Kaliko. However, I suggest that the Karnali region clearly includes other northwestern districts of Nepal such as Bajura, Bajhang, and Dharchula, where inter-regional systems of marriage and kinship, trade, migration, pastoralism, and work have historically overlapped.

<sup>43</sup> There is a tendency to discuss Development (*bikas*) in Nepal using 1950-1 as a temporal bookend, since it was then when the country officially “opened” its borders to the world in 1951. The scope of this chapter precludes an in-depth discussion here, however, confining the concept of development within such a recent timeframe fails to acknowledge the historical and geographic terrain that development traversed in order to arrive at this point, so that, as Goldman (2006: 26) notes, the idea of development as a set of proposed projects could “ring true.” The concepts of development and underdevelopment were actually “invented” long before the end of WWII. As Leys (1996: 5) notes, the idea of development also took on new meanings when France, Portugal, Britain, and other European empires began to formulate ways to maintain economic productivity within their colonies as decolonization approached (Leys 1996: 5). This point is crucial. It is historically appropriate to view “development as an ideology [that] was produced by different actors for different reasons amidst historically specific political projects...shaped as much by historical and geographic contingencies and ruptures as by continuities and inevitabilities.” Development, then, rather than being borne out of the “Truman doctrine” is a reinvigorated project that was “laid on top of already existing geopolitical hierarchies” that emerged from the violence of imperial geopolitics, from conquest, rule, imposed stratification, and exploitation (Sivaramakrishnan and Agrawal 2003: 29; Cooper and Packard 1997: 64; Ferguson 1999: 379).

an increasing awareness of the relative affluence of the rest of the Western world and other benefits of modern technology, a desire for change in the economic base of the country [was] felt.” Western scholarship on Nepal routinely refers to the emergence of Nepal’s “developmentalist state” (Gellner 2007: 9), or the country’s “quest for development” which, according to Whelpton (2005: 12), “took on something of the status of an established religion” with constant sermons and *mantras* often delivered personally by Nepal’s current ruler (2005: 173). Pigg (1992: 498) has argued that *bikās* encouraged, at least to some extent, the formation of an ‘imagined national community’ for Nepalis. Though certainly wrapped up in the ambitions of *bikās*, for Humilis *abikāsit*, or ‘undeveloped’ is a shared regional identity regularly deployed in conversation. Nevertheless, a desire for *bikās* became something that many Nepalis shared and wanted, even while simultaneously understanding first hand its elusive and ambiguous means and ends.

The outright depletion of the country’s coffer by the Ranas made actualizing any aspirations for development rather challenging. Thus, *bikās* came to Nepal first in the form of economic assistance during the early interventionist races that emerged after WWII.<sup>44</sup> In the wake of the Cold War, the U.S. had strong interests in India and those countries on the periphery—and, thus, those feared becoming part of—the Communist world. Like India, America wanted to minimize China’s influence in Nepal. However, this shared interest was often a source of friction between the two nations as they both attempted to implement assistance programs (Mihaly 1965: 87). The United States sought to squelch the radical foment of Communism spreading in the region, as evidenced by a U.S. Department of State’s manual for *Cooperative Program for Aid in the Development of Economically Underdeveloped Areas* (cited in Mihaly 1965: 29):

These people [of the underdeveloped areas] have been stirred by a growing awareness of the possibilities of human advancement...By leaving them unable to fulfill their reasonable aspirations, their misery makes them fertile ground for an ideology which will hold out to them the promise, however false, of means towards a better life.

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<sup>44</sup> At the time (and roughly equivalent today), sixty percent of the national budget was coming from foreign grants and, increasingly, loans (Bhattachan 1996: 87; Thapa 2005: 114).

Commenting on the U.S.'s intentions at the time, Bishweshwar Prasad (B. P.) Koirala directly confronted the veiled motives hidden in the language of underdevelopment: "The American designers of war do not want democracy in Nepal. They want Nepal to fall in line with them in their scheme for world domination in competition with Russia."<sup>45</sup> At the time, Koirala was in exile in India planning the Rana overthrow, and would become Nepal's first democratically elected Prime Minister in its aftermath.

Internationally funded development projects contributed to the expansion of agricultural, educational, health care, and infrastructural projects, which were implemented according to a complex calculus of local, national, and international geopolitics.<sup>46</sup> A slowly emerging network of roads and bridges began to connect the country's centers of commerce and other rural regions, a massive task that is still largely unfinished, owing in part to Nepal's formidable geotopography. At the end of the Rana period there were 276 kilometers of road. By 1990, there were approximately 7330 kilometers (Whelpton 2005: 137). As Tucci (1962: 74) pointed out so long ago, "the progress [Nepal] wishes to attain will remain a utopia if the road problem is not solved first of all" (Tucci 1962: 74).

Connecting the Karnali to the rest of the country was never a priority, and the basis of the region's socio-political and economic dis-integration is a direct result of this neglect. Today, most commodities are still flown up on planes or helicopters to Karnali, increasing their cost by two to five times when compared to elsewhere in the country. For example, eggs costs 30 Nepali rupees (NPRs<sup>47</sup>) (8 NPRs. in Kathmandu), a kilo of sugar costs 250 NPRs. (55 NPRs. in Kathmandu), and a bar of washing soap costs 60 NPRs. (12 NPRs. in Kathmandu). If commodities are not flown in, then they are ferried along Karnali's 'animal pack highways,' a most reliable and dynamic "road system" that traverses the Karnali river, and cuts high passes to reach ancient trading towns across the border in Tibet.

For the most part, though, foreign aid did little to support indigenous modes of trade and production, even in the Tarai, where emerging cottage industries and fertile lands showed the greatest promise (Mishra 2007: 166). The post-WWII geopolitical race by other nation states to intervene in Nepal created serious problems for the fledgling state. Particularly, these nations

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<sup>45</sup> The Hindu, Madras, 17 Feb. 1950, (cited in Mihaly 1965: 28).

<sup>46</sup> See Mihaly's (1965) prescient study of geopolitics and international aid in Nepal, as well as Rose (1971).

<sup>47</sup> At the time of writing at the end of 2012, the conversion rate for \$US dollars to Nepali rupees is roughly one to eighty seven (\$1:87NPRs), while two years ago in 2010 it was one to seventy two.

complicated the task of coordinating development efforts through the creation of an incredibly complex, yet ineffective, bureaucratic system of government, with a multitude of ministry branches and sub-branches (Justice 1986; Mihaly 1965: 173; Rose and Landau 1977). Perhaps most importantly, it laid the path for an economy of dependence that has succeeded in dampening indigenous entrepreneurial spirit, releasing Nepal's rulers from accountability to its people, and further crippling existing forms of collective organization (Bhattachan 1996: 92; Bista 1991: 158; Dixit 1997: 174).

As part of its development efforts, Nepal embarked upon conservation and community forestry programs, which would come to have far-reaching consequences for people in the remote highlands like Humla, who cut-through, herded, grazed, gathered, and propitiated the many spirits and deities in the country's forests for their livelihood and wellbeing. Most of Nepal's forests were nationalized in 1957, and early management policies of the *Pānchayāt Raj* focused on employing villagers as *ban pāle* (forest guards, watchers, and rangers) who 'patrolled and policed' their own forests to deter "encroachment" by villagers—typically their own community members (Bishop 199: 268; Harper and Tarnowski 2007: 47). Households were also now required to purchase permits to fell trees or gather timber for firewood from the newly established District Development Committees (DDCs) located in each district's headquarters. His Majesty's Government of Nepal passed the Community Forestry Act in 1970s, which, along with the Decentralization Act of 1982, was supposedly created to initiate a management system that recognized indigenous stewardship practices; however, in many cases it served to do the opposite. Community 'user groups'<sup>48</sup> were formed with the intent of including all those who directly depend on the forest, especially the landless and the poor (HMGoN 1991: 6), however ultimate authority over forest use was retained by the highly bureaucratic District Forest Office (DFO). As in Rana times, most forest foragers continue(d) to ignore such directives from Kathmandu, and access the forests in accordance with rules and traditions decided communally at the village level.<sup>49</sup>

Thus, while forest conservation policies are generally touted as having contributed,

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<sup>48</sup> These were originally called "peoples consumers committees" before becoming Community User Forest Groups (CFUGs) (Harper and Tarnowski 2007: 40-41).

<sup>49</sup> For example, in the Limi village of Til, there are certain days up until one can cut grass for the coming winter along the hillside. One day, it was noticed that someone had cut in an area that was off limits, and had done so after the end of the gathering period. I watched from a hilltop as all the women in the community together examined the transgression, held councils throughout the day, and eventually came to a resolution through consensus.

legislatively, to more successful and democratic forest conservation throughout Nepal, in practice the propagation of scientific forestry techniques in Karnali had a number of counterproductive ramifications: they destroyed common usufruct rights traditionally held by communities<sup>50</sup>; excluded the poorest of the poor from decision-making processes; promoted *chākari* and *āphno mānchhe*-ism through elite capture of NGO-run projects; and disregarded the kinds of ‘mutli-use’ agro pastoral practices that highland and mountainous communities hold, to the detriment of a healthy ecosystem (Bhattarai, Conway, and Shrestha 2002; Harper and Tarnowski 2007; Nightingale 2005). Beyond this, the loss of mobility for foragers, traders, and agro-pastoralists—now even more restricted in their movements due to further loss of extraterritorial transhumance rights in Tibet (Bauer 2004: 136; Bishop 1990: 311-12)—led to the decline of historical livelihood practices, and the loss of age-old social ties (discussed in chapter six). In Humla, these changes wrought devastating effects on the practice of animal husbandry and other economic pursuits that were based on the backs of animals over great distances. Wagle and Pathak (1997) estimate that up to 80% of all pack animal activity ceased in Humla. In turn, this led to a greater proportion of the population having difficulties in meeting their basic food requirements. In many ways, then, community forestry served as a new form of enclosure that further reduced communities’ viable livelihood strategies, while also serving to accumulate villagers into a newly emerging and highly bureaucratic nongovernmental government.

In the mid-1980s, the Nepali government took *bikās* efforts in a new direction by entering into relations with the International Monetary Foundation (IMF) and the World Bank (WB). Over time, these two major international bodies would come to wield significant influence over the government’s general development policies, and therefore must share some responsibility for some of its failures (Whelpton 2005: 135).<sup>51</sup> During a speech in 1985, King Birendra Bikram

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<sup>50</sup> In addition to relying on sometimes-incommensurate or inappropriate notions of “communities,” community forest user groups created far-too discrete definitions of what constituted agricultural land and forest, which would not map well onto the terrain of mountainous agro-pastoral systems (Nightingale 2005).

<sup>51</sup> Rankin (2004: 168; see also M. K. Dahal 1996: 55) suggests that global fiscal expansion financed by the WB in the mid-1980s resulted in dwindling reserves in international currency; and combined with its downward rate of GDP and growing fiscal deficit, Nepal really had no choice but to enter into an IMF “Standby Agreement.” In 1987 and again in 1989, financed by the WB Adjustment Credits and an IMF Structural Adjustment Facility (Bhattachan 1996: 86; Rankin 2004: 168), SAPs proceeded in Nepal much like they do elsewhere, according to the conditions of the donors. The typical conditionalities followed: the deregulation of capital and “flexible” labor markets, removing price controls, imposing salary ceilings, privatizing state industries, opening borders for trade, and introducing convertibility of the domestic currency (D. R. Dahal 1996: 105; S. P. Sharma 1997). This form of political-economic organization commonly referred to as “neoliberalism” and the IMF and the WB have become the epicenters of policy and knowledge production that promote these administrative institutional reforms. This economic

Shah—son of King Mahendra, and the king who would be murdered in 2001—assured the people of Nepal that the ‘budget balancing’ recommended by the WB was aimed at development, poverty reduction, and improving the overall welfare of the Nepali people “in accordance with Asian standards” (*Ibid*, 127). Through his new economic strategies, Birendra often pledged commitment to the poor specifically, and in 1987 he instituted a formal “basic needs” program (Khadka 1991: 698), which shifted focus to “rural development” and poverty alleviation—the World Bank’s new buzzwords—even while Structural Adjustment Programs (SAPs) continued to cap public expenditures for health care and steered social services towards the private sector (Mishra 2007: 263).

Nepal fell in line with the neo-liberal drive towards free-market policies and privatization, and a range of organizations moved in to finance the switch to selective care. NGOs were promoted to fill the gaps in public services that resulted from reduced public spending (Pfeiffer 2003: 726), with international NGO-disbursed development aid increasing tenfold between 1970 and 1985 (World Bank 1995: 40, cited in Ahmad 2006: 187). Their international growth has been widely noted (Edwards and Hulme 1996a, 1996b; Fisher 1997; Green and Mathias 1997; Kamat 2004; Klees 2002; Nichter 2008a), but perhaps nowhere has this phenomenon been more visible than in Nepal, where, as mentioned, their numbers have soared from 200 in 1990 to figures over 50,000 (Dhakal 2010; Shah 2002; SWC 2009). To the range of ambiguous “state-making forces” that Humli people have historically sought to both escape and engage with, we can now include the growing nongovernmental government that has come to characterize Nepali NGOdome.

SAPs also led to reforms in the state-run Nepal Food Corporation (NFC)—a welfare institution created by the government in 1974 to airlift and sell subsidized grains (donated largely from the United States and Southeast Asian countries) to remote districts to address the growing food shortages and hunger in remote areas, in particular the Karnali districts. After neo-liberalization in Nepal, food depots were closed in districts like Humla, Jumla and Mugu where transportation costs were highest, reinforcing hierarchies in wellbeing across, and within, regions over the next few decades (Pyakuryal *et al.* 2009). Food aid flights and lines of villagers waiting for aid rice became common occurrences at district headquarters and food depots throughout the

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prescription, the whole package—“you can’t cross a chasm in just two leaps” (Easterly 2006: 66)—was purportedly the *only* way to establish economic stability and development. It is, in the words of Ferguson (2006: 83), this IMF-World Bank apparatus that has governed the right way to do development.

Karnali. News of famine and epidemics had also become more regular, as evidenced by some of the headlines that followed after hundreds (estimates range from 350-800) of people in and around the district headquarters of Simikot, Humla died in the winter of 1998. Headlines from local media sources around that time included:

- “Food shortages hit Jumla hard” (*The Kathmandu Post*, 6 April, 1999).
- “Food shortages aggravated by lack of transportation” (*The Kathmandu Post*, 6 April, 1999)
- “Acute food shortages in Mugu likely” (*The Kathmandu Post*, 7 April, 1999)
- “Famine hits Jumla hard” (*The Kathmandu Post*, 9 April, 1999).
- “Influenza ghost may haunt again” (*The Kathmandu Post*, 13 April, 1999):

Adhikari and Bohle (1999: 23) assert that these famines and epidemics resulted from a lack of institutional support in supplying food to the Karnali. There is no clear way of separating out the ultimate and proximate causes of sickness and mortality here. However, Sen (1981) reminds us that poverty and starvation are the result of confluent political and economic conditions of possibilities surrounding the command over food—what he calls entitlements.<sup>52</sup> This approach to understanding hunger is invaluable in an analysis of the political economy of hunger and the concomitant basic rights and needs that structure vulnerability to other forms of deprivation (Dréze and Sen 1989). It is, then, a historical lack of institutional support in addressing all of these basic needs—not simply an absence of medicine distributed at health camps or food in the form of aid rice—that has contributed to deteriorating wellbeing in Karnali.

As Nepali people in regions throughout the entire country began to experience the institutionalization of inequality, political pressure mounted. In 1990, people gathered in mass in the streets of Kathmandu, and eventually outside the palace gates, calling for an end to the *pānchayāt* system. While the *Janā Andolān* (People’s Movement) was not a people’s revolution, it again opened the door for multiparty democracy, an interim government, and a new constitution. Unfortunately, the successions of governments that emerged in the wake of the movement did little to create democratic institutions or implement progressive change, even as a

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<sup>52</sup> See Sen (1976, 1977) for his original discussions of the concept of entitlements as the social and legal means through which one commands available foods.

new constitution was drawn up.<sup>53</sup> As Thapa and Sijapati (2003: 34) note, “the only gesture made towards the country’s diversity in the new constitution was the definition of the nation as ‘multiethnic’ and ‘multilingual,’” though in many ways Nepal continued to be a country dominated by high-caste Hindu tenants and norms. Political parties were also still so engrossed in their own power struggles that they were willing to compromise the mandate of the *Janā Andolān* in exchange for a short stint in power (Thapa 2005: 129). Little was done to give any voice to the majority of Nepali people, comprised of roughly ninety ethnic groups and over one hundred dialects. Thus, the promise of democracy in effect evaporated, and the spoils of development continued to be pilfered and pocketed by the elite. A 1998 World Bank report fittingly sums up the formidable imaginative and geographical distance forged between city and village (as cited in Whelpton 2005: 225):

Urban Kathmandu Valley and the rest of Nepal, in effect, are two separate and unequal countries...In one, around the capital, where 5 percent of the population live, the incidence of poverty is around 4 percent and illiteracy is 24 percent; in the rest of the country, poverty is ten times as high and the chance of being literate almost three times lower.

Meanwhile, disillusionment continued to grow throughout the country, particularly in the countryside. The reporting on events such as the hunger related deaths in 1998 had only become possible alongside the loosening of the control over the country’s media sources following the 1990 *Jana Aandolan* (Adhikari 2008). The realities of histories of oppression and the contemporary conditions of unequal *bikās* were becoming more transparent, contributing to growing frustration that eventually fueled a “People’s War.”

### **‘Ek Ghar, Ek Comrade’ (One House, One Comrade): A People’s War in Karnali<sup>54</sup>**

Pointing to the failure of the new regimes to enact any of the changes mandated by the 1990 *Janā Andolan*, the United People’s Front of Nepal (UPFN) submitted to the coalition

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<sup>53</sup> In the twelve years (1990-2002) following the *Jana Andolan* there were twelve different coalition governments with six different Prime Ministers (see Gellner 2007: 14).

<sup>54</sup> For excellent discussions and analyses of the causes and consequences of the People’s War in Nepal, I direct the reader to Hutt (2004), Karki and Seddon (2003), Lawoti and Pahari (2010), and Thapa and Sijapati (2003).

government led by Prime Minister Sher Bahadur Deuba and the Nepali Congress a document citing their 40-Point Demands, which they believed represented many of the concerns of the Nepali people living in remote areas, particularly the far west.<sup>55</sup> The demands, which were divided into three main sections—Demands Related to Nationalism, Demands Related to the Public and Its Wellbeing, and Demands Related to People’s Livelihoods—came with a deadline: If the government did not take steps towards addressing these concerns, the Maoists would be forced to initiate an armed struggle against the existing state. The other government parties paid little attention to these demands, and this is exactly what happened.

On February 13, 1996 the leaders of the Communist Party of Nepal-Maoist (CPN-M) withdrew from the government, and went underground to launch an armed People’s War (*Janā Yuddha*) against the state.<sup>56</sup> The Maoist’s stated goal was to overthrow the high caste, reactionary and bureaucratic-capitalist ruling classes, and in its place establish a secular republic based on socialist principles. They delivered this appeal to the Nepali people in a leaflet they distributed in the hundreds of thousands titled “March Along the Path of People’s War to Smash the Reactionary State and Establish a New Democratic State!” (cited in Karki and Seddon 2003: 187). They also circulated their social, political and economic goals for a *Naya Nepal*, which resonated among the rural and ethnically marginalized populations who would come to comprise the rank and file of the party. Chief among these were those that recognized ethnic diversity of religions and languages, and promised to abolish discrimination based on caste once and for all; to return land to the tiller and redistribute the land owned by the rich; to improve the provision of drinking water, roads, and electricity to remote areas; and establish the infrastructure for free education and basic health care for all Nepali people. Of course, this had been promised by politicians before, but never had someone shown up with a rifle and said, ‘Here, pick this up. We are going to take what is ours.’

One year after the initiation of armed revolution, the General Secretary of the CPN-M, who went by the *nom de guerre* Comrade Prachanda (meaning, ‘the Fierce One’), released a communiqué titled, “One Year of the People’s War in Nepal.” In this dispatch he outlined the *Maobādi* (Maoist) three-stage process—often referred to as “Prachanda Path”—that followed

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<sup>55</sup> The entire list of demands can be viewed here:

[http://www.humanrights.de/doc\\_en/archiv/n/nepal/politics/130299\\_40demands\\_Maoist.htm](http://www.humanrights.de/doc_en/archiv/n/nepal/politics/130299_40demands_Maoist.htm).

<sup>56</sup> See the introduction by Karki and Seddon (2003: 3-48) to their edited volume, *The People’s War in Nepal, Left Perspectives*, for an excellent discussion of the “People’s War in Historical Context.”

loosely the protracted strategy for agrarian peasant revolution outlined by Mao Tse-tung. He writes:

[E]ver since the days of formation of the centralised state more than a dozen nationalities mostly of the Mongoloid and Austric peoples...who together constitute the majority of the population, have been subjected to political, economic, and cultural domination by the ruling Arya-Khas peoples. In recent years, the contradictions between the state and the oppressed nationalities have sharpened further. Together with this, as a result of the dynamics of polarised development inherent in bureaucratic capitalism, vast mountainous regions and remote areas (e.g., the Karnali region in Western Nepal) have been turned into 'internal colonies' of the centralized state. The process of regional uneven and unequal development is giving rise to sharp regional contradictions in the country...This calls for and provides an apt objective basis for the New Democratic restructuration of the society and state through revolutionary means (sic).

The People's War received surprisingly little attention in the beginning, and was primarily treated as a problem of 'law and order' to be handled by the police (Karki and Seddon 2003: 23). However, in 1998, after a number of successful Maoist raids on police posts in the districts of Rukum, Rolpa, and Gorkha, the government launched a series of repressive and barbaric police operations called Operation Romeo and Kilo Sierra. During these operations, state security forces began to treat all villagers as potential Maoists for intimidation, and often arrested, disappeared, tortured, raped, and killed at random. In the far northwest districts of Nepal, the Maoists had already been able to exploit long-held feelings of neglect and exploitation by the government to marshal support for their cause, and these atrocities only fueled Maoist sympathies in surrounding districts. Slowly, young men and women throughout the country began to join the ranks, or happily supported the party in other ways. Shneiderman and Turin (2004: 90) point out that villagers were overcome with joy when they heard stories of Maoist soldiers burning written records of debt and usury in district administrations. Similarly, Devkota and van Teijlingen (2012) found that populist Maoist ideology resonated with villagers' experiences of neglect, state injustice, and grievances over poor health care services, and these became primary motives for joining the People's Liberation Army's medical wing. Maoist soldiers also came to villages and schools to perform "cultural programs" with dramas and freshly composed songs about a *Nayā Nepal* they were trying to bring about through revolution. Most importantly, as Shneiderman and Turin (2004: 91) point out, while many villagers expected

to be frightened into submission by the Maoists, they were surprised to see that, quite the contrary, they came and sat face-to-face with people, addressed them respectfully, asked for their opinions on issues that mattered to them, and seemed to understand the struggles of their everyday lives. We cannot underestimate the significance of this in examining the underlying support for the Maoist cause.

However, over time, the Maoists would lose the support of many through their own violent dissipations, sexual abuses, kangaroo courts, practices of forced conscriptions, the taking of food and other extortions. It soon became clear that the Maoist top brass were waging a people's war with the people's blood. The Nepali government's increasingly vicious and indiscriminating counter-mobilization of the army and armed police continued to be prone to the same excesses.<sup>57</sup> Both sides continued to engage in extrajudicial killings, and between the years 2001-2003 Nepal had the highest number of disappearances in the world.<sup>58</sup>

As a result, a growing sense of suspicion and silence gripped the public sphere, as people became hesitant to speak out against the Maoists or the state, for one never knew who might be listening, or whom one might offend. A villager explained this tenor of fear to anthropologist Judith Pettigrew (2007: 308):

Anyone could kill you these days and say it was the Maobadi and nothing would be done about it. You could be killed by your enemies or by people who were angry with you for some reason and want revenge. You could even be killed for no reason at all by people who don't like you or are jealous of you. It's frightening.

I recall learning on my very first trip to Humla in 2004 that the body of a man suspected of infidelity with another married woman had recently been tossed in the Karnali river, bludgeoned to death, and found with a red star pinned to his jacket.

Direct, armed conflict reached Karnali only a year or two before that in the early 2000s. In Humla, the Maoists had systematically implemented their "Whole Time" program (WT) through which they forcibly registered one person from each household as soldiers, porters, cooks, donation or information collectors, ideological outreach workers, and cultural program

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<sup>57</sup> A few landmark cases filed against the Nepali Army caught global media attention. Perhaps most famously was the case brought to the Supreme Court by Devi, a *dālit* woman whose daughter was later found to have been raped, killed, and buried by officers of the Nepali Army. This story is retold in the beautiful and wrenching film, *Sari Soldiers*.

<sup>58</sup> Human Rights Watch, *Nepal: Victims Await Justice From New Government*, 9 March 2009, Available at: <http://www.unhcr.org/refworld/docid/49b8e0321e.html>. Accessed 13 October 2012.

participants. This practice was summed up by the Maoist pronouncement of '*Ek ghar, ek comrade,*' (One house, one comrade). As told to me by several Humlis, Maoist cadre would leave a shoe in front of a household's door, which signified that they were supposed to send someone to the nearest *Maobādi* camp. Sometimes rebels showed up unannounced and said that a family member had to come right then and there. In this manner, entire communities were initiated into the party, making it difficult to refuse shelter, food, or clothing to other Maoists who came knocking on doors under the cover of night. I heard from many interviewees their personal opinion that Humla was the district with the most number of "Whole Timers" in the entire country during the *Janā Yuddha*. Still, other villages were able to successfully negotiate their way out of this program of conscription. One Tibetan community near the border of Tibet in Humla managed to get the Maoists to agree to relieve them from the Whole Time program in exchange for assistance with unloading and carrying equipment (military boots, uniforms, and weapons) up over the Nara La pass that cuts down into the Karnali basin from the border of Tibet.

While differing across and within districts, overall the conflict had mostly adverse impacts on agricultural production, animal husbandry, trade and pastoralism (Adhikari and Seddon 2003), further diminishing entitlements and constraining life chances. Food shortages that often resulted from crop disease and unpredictable weather were exacerbated by the massive exodus of labor as villagers fled the fighting and headed to Kathmandu, another nearby town, or India. However, discussions with several households in Humla revealed that, for some families, agricultural production increased during the conflict, as villagers would head out earlier than normal in the morning and stay much later in higher and further off fields to avoid harassment from *Maobādi* who wandered frequently into villages. I discuss this further in chapter six.

Maoists also blew up bridges and rope tows that led across otherwise non-traversable rivers, and they restricted free movement; one could only go to the district headquarters if given a 'chit' signed by a commanding officer. Soldiers ransacked health posts for materials such as solar panels, inner fittings, medicines and other equipment. Doctors and government health care workers (HCWs) fled their posts in large numbers, fearing extortion by Maoists who came demanding portions of their salaries, often under the threat of violence. On occasion, Maoists also forced NGOs to pay out a portion of their budgets and targeted specific Nepali NGO employees, often accusing them of "working as imperialist stooges to divert the rural masses

from real contradictions and struggles” (Shah 2002: 143).<sup>59</sup> In the district of Humla, the Maoists had succeeded in completely halting the construction of a road from their district headquarters of Simikot to the border of Tibet. Funded by the UN’s World Food Program (WFP), and administered by an assemblage of NGOs, this project compensated temporary laborers from nearby villages in bags of rice. In line with their Marxist roots, the Maoists condemned the project as a specific capitalist process that extracted surplus labor and lorded over peasant life. One man told a friend and me over glasses of *raksi* that they stopped the road construction because it was using bombs, which, when detonated, only benefitted those who profit from making and selling bombs. The obvious irony, here, of Maoist ideological and monetary profit from their own use of bombs is perhaps overshadowed by the sadness of a revolution fought in the name of a people who are then denied the chance to work and get food while building a much needed road.

On June 1<sup>st</sup>, 2001—one day after I left Nepal for the very first time—King Birendra and most of the royal family were killed in a mysterious massacre that, to this day, remains obscured in uncertainty. Following the death of Birendra, his brother—the unpopular Gyanendra—became King and, four years later, he dismissed parliament by declaring a state of emergency to counter the Maoists. This thinly veiled move to assume sweeping power led to mass protests in the streets, which culminated in the 2006 second Peoples Movement for democracy, or *Loktāntra Andolan*, which preceded the formulation of the first Maoist-led coalition government after a Comprehensive Peace Agreement (CPA) was reached between the Maoists and the outlawed political parties. This effectively brought a decade-long conflict to an end on paper; however, the settling of grievances and wrongdoings persisted well after the agreement. Just as during the conflict, the label of *Maobādi* was often attached ad hoc when needed for the justification of violence.

After the peace agreement, the Maoists no longer hid in the jungles, but rather established a party headquarters in Simikot that proudly flew the red hammer and sickle flag. People in Humla were already disillusioned by the ambiguous and muddled presence of a largely absent state—present only in the forms of the police, the army, and the few administrative offices in Simikot, and the periodic campaigning of constantly changing local politicians, who sometimes

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<sup>59</sup> Demand number nine of the original forty demands issued by the UPFN on behalf of the Maoists dealt explicitly with this: “Bribing by imperialists and expansionists in the name of NGOs and INGOs should be stopped” (as cited in Karki and Seddon 2003: 184).

(though rarely) came to villages. However, the Maoists formed local committees to carry on as a parallel governmental body. And, while they agreed to disband their kangaroo courts and other juridical systems established throughout all 75 of Nepal's districts during the course of their struggle, they formed the Young Communist League (YCL)—a 'youth wing' of the Maoist party that utilized strong-arm and often violent tactics to "support the revolution."

I would come to find during my time spent in Humla that—despite their violent and extortive practices—Maoist sympathies remained, but were often ambiguous and contradictory, reflecting the wide gap between the promises and plans made by the Maoists and their fulfillment (Pfaff-Czarnecka 2004). People often lamented the party's ideological dismissal of religion, and were horrified at the acts of sacrilege perpetrated by Maoist soldiers in the name of secularism: such as entering temples and holy shrines on inauspicious days, destroying their contents, and disavowing the powers of local healers and priests, even while many Maoists remained patrons of these practitioners themselves. On the other hand, villagers were pleased with the level of consciousness raising that the Maoist conflict ushered in, and indeed a newly politicized language of desires, needs, and participation seemed present in conversations I had with Humlis about wanting their "rights" (*hak*) to education, employment, food, and health care. Yet, people would then turn around and lament that the revolution and change promised by the Maoists had yet to materialize. I agree here with Catherine Sanders (forthcoming), who argues, that perhaps one of the reasons villagers came to view both Maoists and NGO workers over time with similar reluctance was that, in many ways, "both of their claims and concerns were equally foreign, difficult to evaluate, and sounded a lot like the failed promises villagers had heard before."

## **Contemporary Landscapes of Health, Healing, and Hunger in *Nayā Nepal***

### ***Playing Politics with the Health(care) of the Nation***

In 2006, Nepal held its first free general election in over nine years in an attempt to form a more 'inclusive' Constituent Assembly (CA), which would be charged with writing a new constitution. The Maoists won the majority of seats in a landslide victory, which surprised many in and

outside of Nepal. It turned out that Nepali people proved willing to forgive or look past the violence Maoists used to arrive at the place where they could go ‘from bullets to ballots.’ They were eager to see if the Maoists’ promises of transparent democracy, ethnic inclusion, resource redistribution, and other “people-oriented” (Nepali: *janā mukti*) declarations could become a reality. Most likely, it seems to me, the Maoists were given a chance to govern because the party offered the only alternative to the same politicians that had been trading power back and forth for decades, and had delivered very little on their populist rhetoric of *bikās*. Perhaps the Maoists would be different.

After the 2006 elections, the Maoist-led coalition government took up as their first order of business in *Nayā Nepal* the abolition of the institution of monarchy, and declared Nepal the world’s newest federal republic. More people-oriented health care policies—returning to a focus on health as a human right and tackling disadvantaged regions and groups—came to the fore of health policy discussions, especially following the April 2006 *Loktāntra Āndolan*. In September 2008, the Maoist-led government announced a keystone public sector program in *Naya Nepal’s* first federal budget that aimed to provide free health care services, including village-level scale up, the construction of new health and sub-health posts, and free maternity services to all Nepali people (Peterson 2008). The “New Nepal: Healthy Nepal” initiative was, perhaps at the level of thinking, a conscious effort to begin to repair damage done to the already-struggling health care system during the conflict.

However, these plans were never to see the light of day, as the former Maoist guerrilla-cum-Prime Minister withdrew the CPN-M from the government within a year, and as with every successive government that came to replace its predecessor, previous policies and projects were jettisoned, at times seemingly for ideological and political showmanship. As I complete this dissertation at the end of 2012, the CA has been disbanded, and the task of writing a new constitution remains unaccomplished. Party politics continue to plague Nepal’s health care sector. One reads constantly in Nepal’s news media of corruption and nepotism charges, strikes, walkouts and protests at teaching hospitals and institutions of medicine. *Āphno mānchhe* and favoritism is rampant in the process of appointing institutional positions, as evidenced by the recent replacement of the Vice Chancellor of the Patan Academy of Health Sciences (PAHS) in Kathmandu by another with close ties to powerful politicians.<sup>60</sup> S. P. Sharma (2010) also

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<sup>60</sup> See Kim Lama’s “Bad Prescription” in the *Nepali Times*:

documented the sacking of doctors who were then replaced by others with allegiance to powerful politicians. These internecine struggles have become the hallmark of Nepali politics at the cost of concerted action to improve the health and health care of the Nepali people.

Statistics, too, present a complicated, if incomplete, picture of the current landscapes of health and healing in Nepal and Humla. Accurate data is simply elusive, if non-existent, though I discuss statistical representations of health and hunger further below. Here, though, a brief outline of Nepal's healthcare system is required.

### *A Brief Historical Overview of Nepal's Healthcare System*

As mentioned above, it wasn't until towards the end of the Rana period in the late 19<sup>th</sup> century that the health of the larger Nepali population became a focus of the rulers. Prime Minister Bir Shumsher constructed the first hospital—Bir Hospital—in Kathmandu in 1890 (1947 v.s.), and eventually others in the administrative headquarters of several other districts, to promote allopathic medical services.<sup>61</sup> In 1933, the Department of Health Services (DHS) was established to regulate the slowly growing number of hospitals (by that time 33) in urban areas, and a few other medical services like Ayurvedic schools and dispensaries. After Nepal loosened control of its borders in 1951, a range of nations and external donors began to assist in the development of a health care system in the country. First among them were India, the United States, and the World Health Organization (WHO). Over the next five years, Nepal's emphasis placed largely on training physicians in India under the Colombo plan and on building limited capacity in nursing (Dixit 1995: 51; Sigdel 1998: 20) changed to focus on growing curative services more broadly throughout the country. In 1956, the DHS was subsumed through the formulation of Nepal's first Ministry of Health (MoH), and a process of writing five-year plans (or sometimes 'long term strategic ten-year plans') was established. This ushered in the beginning of perpetual and frequent changes in governmental policies, funding trends, and infrastructure in Nepal's health care system, of which only a cursory overview is offered here.<sup>62</sup>

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[http://nepalitimes.com/issue/2012/11/28/Nation/19799#.ULWP2eOe\\_6Q](http://nepalitimes.com/issue/2012/11/28/Nation/19799#.ULWP2eOe_6Q).

<sup>61</sup> These hospitals were to be called "Prithvi Bir Hospitals," named as such because the ruling king at the time was King Prithvi Bir Bikram Shah and the PM was Bir Shumsher Rana.

<sup>62</sup> See Dixit (1995: 51-73) and Sigdel (1998: 21-34) for detailed discussions of these changes during the first ten five year plans in Nepal, and the international and national politics that surround these changes. At the time of writing, Nepal is currently coming to the end of its Eleventh Five Year Plan (2007-2012).

In addition to the construction of health- and sub-health posts, and district, zonal, and national hospitals, His Majesty's Government of Nepal (HMGoN) worked with the WHO in the first few five-year plans to implement and “integrate”—a key policy word for Nepal's process—smallpox and malaria eradication programs, as well as ‘vertical, disease-specific programs’ such as tuberculosis (TB) and leprosy control projects. Other public health campaigns like family planning (FP) and maternal and child health (MCH) programs followed shortly after (Dixit 1995; Justice 1986; Sigdel 1998). During the transition from the Fourth to the Fifth Five-Year Plan in the mid and late 1970s, more emphasis was placed on preventive aspects of health care, which reflected the global tenor that followed the signing of the 1978 Declaration of Alma Ata at the International Conference on Primary Health Care (PHC). Nepal was one of the 134 signatory countries to this document, which stated that governments would implement changes in policy, projects, and infrastructure to work towards “Health for All by 2000” by focusing on self-reliance, ‘appropriate medical technology,’ and community participation. This shift was reflected in the training of newly minted “Village Health Workers”—modeled after the social experiments in healthcare underway in places like North Vietnam, Cuba, and China—as well as in the alteration in name from Nepal's “Integrated Basic Health Services” program to the “Integrated Community Health Program.” The name change, however, was not enough to bring about the intended results, and this shift met with limited success (discussed further in chapter five) (see Justice 1986).

By now the training of a range of existing and new medical personnel (Auxiliary Health Workers, Auxiliary Nurse Midwives, Health Assistants, and Village Health Workers) was being overseen by the newly established (1972) Institute of Medicine affiliated with Tribhuvan University. The Seventh Five-Year Plan (1980-1985) in Nepal had a more explicit focus on increasing this workforce, and integrating them into basic health care services throughout the country. The Eighth Five-Year Plan (1992-1997) picked up two years after the 1990 *Janā Āndolan*, and it marked the first plan drafted and announced by a democratically elected government. The “New Health Plan,” as it was called, focused on both “coordination and decentralization” of health care services and the steady procurement and distribution of essential drugs, as well as set specific targets related to increasing life expectancy and reducing child mortality, maternal mortality, and fertility rates (Sigdel 1998: 27-28). It's stated goal was the “attainment of the highest possible level of health by the Nepalese people” (sic) (cited in Dixit

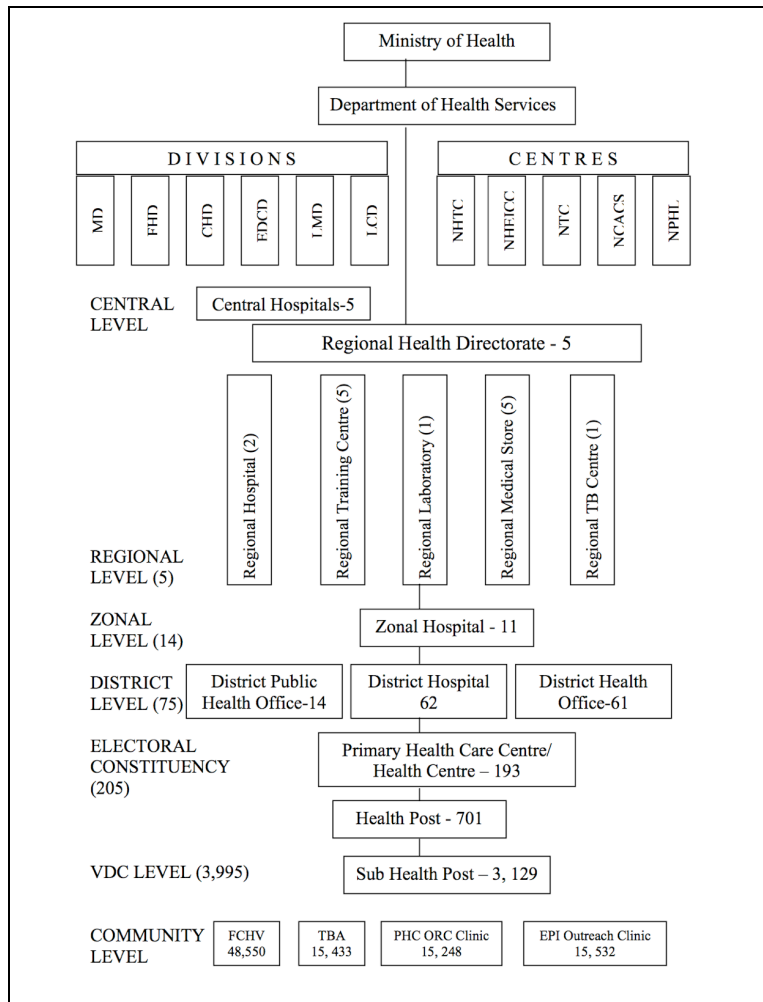
1995: 63), though looking at the meager allocations of the yearly budget for health care during this plan—which tops out at 5.16% in 1994/1995—seems to tell a different story.

In large part, funding was a primary reason for the Nepali government’s continued enlistment of NGOs and other external donors and nations. They have become dominant actors in Nepal’s Ninth (1997-2002) and Tenth Five Year Plan (2002-2007) through “Public Private Partnerships” (PPPs) that formalize their prominent role in assisting Nepal’s MoHP in the continued, if elusive, vision of an “integrated health care system” (Dixit 1995: 71) and strive for further improvement in health indicators as dictated by the Millennium Development Goals (MDGs).

Nepal’s current health care system is structured partly in accordance with the state’s larger administrative and developmental units. Nepal is currently divided into fourteen administrative zones (*anchal*), which are grouped into five development regions, each with their own health directorate. The fourteen zones are further divided into 75 districts (*jilla*) each headed by a chief district officer (CDO). Districts are then divided into village district committees (VDCs), and nine wards exist within VDCs. In terms of an overarching structure of the health care system, at the central level, the Ministry of Health and Population (MoHP) oversees the national health care system divisions and centers. Each administrative zone has a hospital overseen by the Regional Health Office (RHO). Most districts have a hospital run by the District Public Health Office (DPHO) and the District Health Office (DHO), and they are staffed by a District Health Officer (DHO)—who typically holds a Bachelor of Medicine/Bachelor of Surgery (MBBS)<sup>63</sup>—several health assistants (HAs), and sometimes an auxiliary nurse midwife (ANM). At the district level, health care services are available at primary health care centers and health posts, with sub-health posts at the VDC level; all with varying levels of filled posts and absenteeism depending on the region.

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<sup>63</sup> These are the two professional degrees received after the completion of medical school in countries that follow the United Kingdom system of medical education.



**Figure 2.4** Organizational structure of Nepal’s Ministry of Health and Population (MoHP) and health sector figures. Source: WHO<sup>64</sup>

In Humla, for example, there is one district hospital, and throughout Humla’s 27 VDCs, there are ten health posts and sixteen sub-health posts. Some of them are staffed by Village Health Workers (VHWs) There are reportedly thirty-five nurses in Humla, five ANMs, one Ayurvedic doctor, and three MBBS doctors (MoHP 2007). However the latter—used to the amenities of more cosmopolitan areas—rarely stay at their posts in the district hospital and often find reasons to fly to Kathmandu or other urban areas for trainings, seminars, and extended holidays. In addition, skilled birth attendants (SBAs), village health workers (VHWs), and cadres of Nepal’s renowned Female Community Health Volunteers (FCHVs) serve communities. These FCHV local women work voluntarily as lay health care providers in their own communities, and have

<sup>64</sup> Available at: [http://www.searo.who.int/LinkFiles/Nepal\\_Profile-Nepal.pdf](http://www.searo.who.int/LinkFiles/Nepal_Profile-Nepal.pdf).

become an integral part of Nepal's community-based primary health care system, acting as community mobilizers, health educators, and a key referral link between rural health care services and communities (Glenton *et al.* 2010; WHO 2010).

In terms of biomedical practitioners and workforce, according to the World Health Organization (WHO 2009: 100), there are only 5,300 physicians (MBBS) in Nepal—most of which are clustered in Kathmandu—and their number per 10,000 is two.<sup>65</sup> One aspect of Nepal's health care brain drain can be seen in the numbers of graduating physicians in Nepal that now work overseas: in 2003/4, 53.5% of graduating medical students went to work abroad, compared to 14% of the first batch of students graduating between 1983-1987 (Zimmerman *et al.* 2012).

However, these numbers refer to biomedical physicians only, and do not include the range of other traditional healers and specialists found in Nepal's range of ethnomedical systems,<sup>66</sup> which, though distinct, continue to actively blend in a plural healing landscape. While an exhaustive discussion of therapeutic healing modalities in Nepal is outside the scope of this dissertation, it is important as a stopping point in order to contextualize the discussions about health and healing in later chapters, and to better grasp the worlds of Humli villagers that require traditional healers and other specialists to deal with everyday problems of livelihood, health, illness, and death, satisfying a range of human predicaments no purely epistemic medical system is able to address in isolation (Maskarinec 1995: 94).

### ***Therapeutic Modalities and Plural Healing in Humla***

Nepali healing beliefs and practices are rooted in complex, interrelated universes of seen and unseen forces. This is because health is conceptualized in a broad, pervasive sense that extends beyond the individual body to include notions of familial, social, and cosmic order and wellbeing in the past, present, and future. These dimensions of life function in a concentric system whereby any one unaligned part can upset the whole. Eating the wrong foods can offset the internal balance of the body and illness can ensue, just as failing to appease a local god (*deutā*) that lives in the forest may result in other physical harms. The interventions of ghosts [*bhut*] and other

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<sup>65</sup> This compared to India (6:10,000) and Sri Lanka (6:10,000), Bolivia (12:10,000), Costa Rica (13:10,000), the U.S. (26:10,000), and Cuba (59:10,000) (WHO 2009: 100).

<sup>66</sup> My conceptualization of "ethnomedicine" is a fluid one that refers to the beliefs and practices relating to sickness and affliction that are the syncretic result of indigenous cultural developments as they shape, and are in turn shaped by, other medical traditions and systems.

supernatural forces can generate misfortunes such as crop failure, problems with money, threats to fertility, or the death of a family member or animal. In Humla, therefore, people try to live in ways that procure harmonious, healthy lives by seeking a balance of body, spirit, and society. This includes trying not to anger their neighbors, or be the object of jealousy, for this may invite the evil spells of witches (*bokshi*) or sorcerers (*boksha*). These etiologies—or theories of causation—can be approached using a dual classification typology that, while not mutually exclusive, helps to differentiate between sickness and misfortune that is “personalistic” or “naturalistic” in nature.

Personalistic medical systems attribute illness to “the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or god), a nonhuman being (such as a ghost, ancestor, or evil spirit) or a human being (a witch or sorcerer)” (Foster and Anderson 1978: 53). In Humla, for example, staying healthy requires local knowledge about avoiding the streams and water sources where deities live, which villagers learn to identify as young children by the colored ribbons hung from trees nearby. People avoid carrying food out in public, especially uncovered, as this is said to arouse the appetite of evil spirits. And, Humlis regularly burn dried juniper incense (*dhūpi*) when they cross high passes—the abode of local divinities—and place offerings of fruit or honey at the roots of ancient trees in propitiation of a pantheon of Hindu, Buddhist, and animist gods and demons that can willfully cause human suffering.

Naturalistic beliefs about illness, on the other hand, are explained in impersonal and systemic terms, and are rooted in conceptions of balance. So, while health can be threatened by outside forces and agents, it can also be promoted and maintained through seeking equilibrium, whether in the five elements of the body (earth, air, fire, water, and ether), the corporeal humors or *dosha*, or in the consumption of “hot” and “cold” foods. Throughout Nepal, foods are classified as either possessing inherently hot or cold properties, and so eating has nutritional as well as other vital implications for maintaining the body’s balance. Applying Nichter’s (1996: 50) concept of “folk dietetics”—lay understandings of physiology as they relate to classifications and restrictions of hot and cold foods—Harper (2003) discusses how women in Nepal’s Pālpā district would avoid certain hot foods like fish and eggs during pregnancy, during which the body tends to generate excess heat. However, different foods are eaten and avoided as the body cools during post-partum, such as green leafy vegetables believed to pass their chilling properties

through breast milk to infants. These understandings and practices surrounding eating are pervasive in Humla.

In Humla, people also interact with biomedical practitioners like doctors, nurses, health assistants, and axillary nurse midwives at health posts and the district hospital. Pharmacists in the district headquarters (licensed and unlicensed) are also sought out in discussions over treatment (cf. Subedi 2001). However, this care can be costly, and distant—in geography and manner of staff—and is more readily sought out in Humla by those with cash, or in emergencies as a last resort (Sanders, forthcoming). Decisions about seeking this care also depends on perceptions of treatment by medical personnel, which often has to do with the way villagers present themselves at these clinics: the language they use, the kinds and cleanliness of their clothes, their perceived class, caste, and the darkness of their skin; in Nepal, having a dark complexion is looked down upon, and makes people clear signs for discrimination.

Many other factors also mediate an individual's access to these services; such as transportation costs, a person's social status within a household, and the time of year one gets sick. Sometimes, these combine in a gendered politics of health and care, which I observed while conducting research in 2010 when I spoke with a women in southern Humla whose husband would not take her to the district hospital for testing or treatment, despite showing what they both knew to be telltale signs of tuberculosis—severe fevers, chronic loss of weight regardless of food intake, and the habitual coughing up of blood. The harvest was upon them, the husband said, and the household could not get by without the woman's labor.

The principal forms of healing in Humla are typically household remedies provided by family members.<sup>67</sup> These therapies include the use of *jaDibuTi* (medicinal herbs, plants, flowers, and roots), and the practice of consuming foods known to restore the body's balance or have inherent healing properties. In Humla, for example, people often treat gastrointestinal pains with a slightly warmed drink made from fresh goat's milk, honey, ginger, and ground *timur* (a Nepali variant of the Szechuan pepper).

When home remedies do not achieve the desired outcome, Humli people consult other specialists and healers. And, because illness episodes can have multiple etiologies, people often seek out a range of practitioners to address the immediate (proximate) and underlying (ultimate) dimensions of afflictions, which are often interrelated. As Young (1976: 19) notes, “sickness is

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<sup>67</sup> Freund and McGuire have accurately referred to the family as “the hidden health care system” (1999: 170-175).

an event that challenges meaning in this world, [and] medical beliefs and practices organize the event into an episode that gives it form and meaning.” In Humla, those who are often more able to do this in a way that villagers will understand include a range of specialists including shamans, but also formally trained Ayurvedic doctors called *vaidya*, and religious practitioners like Tibetan *amchi* and priests (Lamas). In Humla, these revered Lama practice a particular blend of Buddhism mixed with shamanic-animism. Along with *amchi*, who deal in the spiritual practice, art, and science of Tibetan medicine, Lama are practitioners that intercede in both seen and unseen conditions and forces that mediate everyday life and relationships. They heal through performing special rituals to eliminate negative energies and enrich the surrounding environment, which includes fields, homes, and hearth. Lama divine karmic patterns that are determined by past actions, they interpret dreams, and mediate negative emotions that intersect with one’s spiritual path and journey. Lama and *amchi* are also integral to celebrating the many festivals celebrated in Humla by various ethnic groups, often in accordance with the seasonal harvest cycles or, in the case of Buddhist communities, the Tibetan lunar calendar.

In Humla, there are a range of other shamanic practitioners—*dhāmi*, *jhānkri*, or *jhārfukne*—who use local “explanatory models” (Kleinman 1980) and employ a wide range of folk diagnostics and therapies to “see” (*hernu*) over events in the past or future, and to name and tame sickness.<sup>68</sup> *Dhāmi* remain a crucial part of Karnali’s plural healing landscape, and they have the power to divine, to propitiate and exorcise, ‘interceding in and make sense of the interrelatedness and everydayness’ (Maskarinec 1995: 21) of illness, life and death, accidents and misfortune, sleep and dreams, spirits, ghosts, and witchcraft, astrological impasses, fertility, and family issues. In Karnali, they are part of a regional medical syncretism that continues to celebrate a more egalitarian, flexible socio-moral world that accounts for pliable beliefs around healing that give Karnali’s “cultural kaleidoscope” (Bishop 1990: 119) an “elasticity” (Whelpton 2005: 57) that is indeed unique to the hilly and mountainous regions throughout Nepal. Trance-centered altered states, chanting, drum beating, mantras, herbal remedies, and animal sacrifice are some of the ways these specialists commune with the extant and invisible to retrieve lost souls, cast out evil spirits, and propitiate ancestors. Ceremonies, themselves, are often heard (by

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<sup>68</sup> In Humla, these healers are typically referred to as *dhāmi*, and therefore that is the term I use throughout the rest of this dissertation. For more in depth discussions of these traditional healers and systems in Nepal see, for example: Allen (1976); Desjarlais (1992); Hitchcock and Jones (1994 [1976]); Holmberg (1989); Miller 1997 [1979]; Peters (1979, 1981); Stone (1976).

non-participants) before they are seen, as the steady *dyang-dyang-dyang* of the *dhāmi* summoning his personal god through drumming is audible from anywhere in the village. Always seated to begin, often beside a fire, *dhāmi* drum softly, then more rapidly, head slumped forward, slowly shaking until the crescendo builds to full on convulsions. Long manes of uncut hair fall from their cloth wraps, as the *dhāmi* stands up to drum more forcefully, spinning as he enters a trance. With juniper incense burning—something common to both Tibetan Lama and *dhāmi* in Humla—*dhāmi* divine over plates of uncooked rice grains to identify the causes of affliction. Slowly sift through the granules, eyes closed trembling, seeing but not looking, until something causes him to stop over one, then another. Sometimes, he picks up several grains and scatters them in the air with an upward flick of his wrist. Some he picks up and places back on the plate. Other pieces of rice are given to the client to eat, or to later toss in the fire after they have gone, or to put away for safekeeping. *Dhāmi* utter careful instructions passed down to him from his incarnating deity, and ceremonies only end when his personal god leaves the body.

This breadth of indigenous medical practices and practitioners is crucial in conceiving of “primary” health care throughout Nepal, as it encompasses many people’s first choices in healing patterns of resort, regardless of proximity to more “modern” health care facilities (Gellner 1994; Subedi 2003). This is especially true in Humla and throughout the Karnali, where oracular *dhāmi* continue to intercede in the lives and worlds of villagers in matters that range from crop failure and problems with animal husbandry to intimate issues of familial life and death and practices of reproductive health. As we will see in chapter five, they even assist Humli people in the selection and preparation of health camp medicines. As Gregory Maskarinec (1995: 94) has beautifully argued, interactions with local healers are “more familiar, less frightening, and less intrusive than is Western-style medicine, its practitioners less condescending and far easier to understand, and its success rate is no worse than its competitors.”

It is also important to have discussed the range of plural healing modalities above precisely because they are not mentioned or addressed with even one word in the national demographic and health surveys (DHS), which are supposed to accurately reflect the health status and patterns of health care service utilization in various regions of the country. The goals of these data collection tools are to help guide policymakers, country leaders, researchers, and the state to improve the health and health care of its people. To do so without discussing local medical belief systems and healing practices is, in fact, quite careless.

## ***Statistical Representations of Health and Hunger in Nepal and the Karnali Zone***

While the process for calculating statistics in Nepal is an admittedly imprecise process,<sup>69</sup> they offer a baseline for country-to-country comparisons, and highlight inequalities—and the larger gradients of socio-economic development and wellbeing—within countries. Nepal’s 2006 Demographic and Health Survey (DHS) (MoHP *et al.* 2007) points to some improvements in national health status, such as a reduction in maternal mortality ratio (MMR) from 539 per 100,000 live births in 1996 to 281 per 100,000 in 2006. Data also show that infant mortality has declined by 41 percent over the five-year period preceding the survey, from 82 deaths per 1,000 live births to 48. Under-five mortality dropped to 61 per 1,000 live births for the same period, putting Nepal on track to meet the Millennium Development Goals (MDGs) for maternal and child mortality. Yet, this still means that one in every 21 children dies in the first year of life, and one in every 16 before age five (MoHP *et al.* 2007: 125).

Nepal’s most recent 2011 DHS (MoHP *et al.* 2012: 147) highlights other improvements in health indicators, such as the doubling in the percentage of children age 12-23 months who are fully immunized in the past 15 years from 43% in 1996 to 87% in 2011. Infant mortality dropped a bit further in the past five years from 48 per 1,000 live births to 46, and the under-five mortality rate dropped to 54 deaths per 1,000 live births.<sup>70</sup> Yet again, this still means that one in

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<sup>69</sup> For example, Tsai (2009: 516) notes that there are wide confidence intervals around the MMR (obtained by dividing the age-standardized maternal mortality rate by the age-standardized general fertility rate) reported in Nepal’s 2006 DHS, but a real drop is likely to have occurred. This is interesting given that the reduction occurred partially during the years of the People’s War, when access to health care services was greatly limited. The MoHP attributes this decrease in part to increased knowledge and use of contraceptive practices (MoHP *et al.* 2007:4). However, I wonder if there were also fewer marriages and subsequently fewer births during the fighting, as young men and women of reproductive age fled villages, joined or were conscripted into the conflict. In short, we must be careful in drawing conclusions about health trends from statistical interpretation alone because the collection of vital statistics—especially in remote parts of Nepal—is an admittedly inaccurate process that results in varying quality of data, time references, and sample coverage. Sampling in the Karnali zone, and in places like Humla in particular, are rarely done in representative ways, in large part because of the inaccessibility and the highly mobile populations who are away from households trading, grazing animals, or doing wage labor in Tibet, India, or abroad. “In particular,” we are told for Nepal’s 2006 DHS, “sampling errors associated with mortality estimates are large and should be taken into account when examining trends between surveys” (MoHP *et al.* 2007: 125).

<sup>70</sup> With this reduction, and in a reversal of historical trends, Nepal now has a lower infant mortality rate than India (48 per 1,000 live births), and continues to perform better than Pakistan (70 per 1,000 live births), though it has not yet surpassed Bhutan (44 per 1,000 live births), and other countries in the South/Central Asian region like China (16 per 1,000 live births), Mongolia (26 per 1,000 live births), and Sri Lanka’s (14 per 1,000 live births) clearly indicate that having political will to implement progressively funded and people-oriented policies that both prevent and treat sickness is crucial in achieving improved health outcomes.

every 22 Nepalese children dies before reaching age one, and one in every 19 does not survive to his or her fifth birthday (*Ibid*, 111).

**Health and Hunger in the “Hidden Himalayas”**

Indicator	National	Mountainous Region/ Humla
Life Expectancy	66	54 (Humla)
Under-5 mortality (per 1000 live births)	61	128
Infant mortality (per 1000 live births)	48	99
STUNTING - (height-for-age) (%)	49	72 (Humla)
WASTING - (weight-for-height) (%)	13	90 (Humla)
Global Hunger Index (GHI) = Proportion Undernourished + Underweight Prevalence + U-5 mortality	19.9	40.17 (Humla) = Democratic Republic of Congo

Sources: Nepal 2006 Report 2065/66 v.s. [2008/2009]; 2006 NDHS; UNDP 2004

**Table 1.1** Statistics, though often unreliable (See fn. 61), give a sense of the regional inequalities that persist in Nepal.

Perhaps most importantly, aggregate national health indices continue to mask considerable disparities across geographical regions, gender, class, and caste in Nepal (Tsai 2009: 516; World Bank 2004: 1) (Figure 7). For example, Nepal’s Gini coefficient—the most widely used measure of inequality—of disposable income and consumption expenditures increased from 0.30 in 1984 to over 0.38 in 1996 and further to 0.47 in 2004 (Wagle 2007; World Bank 2006). Life expectancy in urban Nepal is 68, while in the Karnali district of Mugu it remains 44. In the neighboring district of Humla, life expectancy is 54, and it is ranked 75 of 75 districts in Human Poverty Index (HPI), literacy rate, and per capita food production, yet 7<sup>th</sup> in per capita development expenditure, and an estimated 90% of children under-five suffer from chronic malnourishment and 72% from stunting (Adhikari 2008:10-13). According to the spokesperson for the UN WFP, the sub-regional global hunger index (GHI) for the mid-western mountain region (read: Karnali) is comparable to that of the Democratic Republic of Congo, the worst

scoring country of all GHI countries. Under-five mortality in the mountainous zones (128 per 1,000) is more than double that in the hills (61 per 1,000) (MoHP et al. 2007:126), and epidemics continue to claim hundreds, and stand as glaring reminders of the basic public health work left to be done (Nepali Times 2009; Sejuwal 2009; Tuladhar 2009).

Indeed, it is precisely this governmental inaction along with the chronic conditions of scarcity in which many Karnali residents still find themselves that has contributed to the growth of a nongovernmental state that intervenes in the form of flown-in food aid and short-term medical camps, and draws medical volunteers to go and ‘do good.’ These fleeting forms of care emerge most saliently in the contexts discussed above—where contemporary histories of violence couple with the widespread conditions of poverty, hunger, and disenfranchisement. Against this backdrop, the provision of free medical care or food, by any group, represents more than just humanitarian gestures of goodwill or attempts to improve health and wellbeing.

Yet, an overwhelming desire to help in this part of the world remains a major motivating factor for the range of *bideshi* medical practitioners who engage in short-term volunteer work, often through health camps and other forms of direct medical service delivery. In chapter four, I examine the circulations of these ‘modern medical missionaries’ in Nepal by exploring the active and ambiguous social and political lives that surround medical voluntourism as a prominent model of short-term care delivered by people drawn by representations of untouched, out of the way places and the people in need of healing. In the next chapter, I’d like to go first to Humla to describe some of the textures of everyday life when there are no medical volunteers present, and no health camps or food aid distribution events.

## CHAPTER THREE

### Finding the “Hidden Himalayas”: In (Re)Search of Everyday Life in Humla

The late Dr. Harka Gurung (1980: 93) notes that, to most people, “Humla is a mere jingle word appended with Jumla.” I suspect he is referring to the refrain of a popular Nepali folk song, which—with the exception of a few short stretches of road<sup>71</sup>—continues to ring true so many years later: “*Humla-Jumla gāDi mā, kahile jāne ho?*” (When will we be able to go to Humla-Jumla in a car?). Indeed, roadlessness contributes mightily to Humla’s place in the national consciousness as a remote and backwards district where life is grueling. The writings of trekkers, development workers, and volunteers often perpetuate these representations. In his *Nepali Times* editorial, “Becoming Humli,” Kayastha (2009) moved from Kathmandu to Humla’s district headquarters, Simikot, to work for a prominent NGO. He writes that life is harsh in this place “so remote it calls to mind Soviet-era Siberia.” Grennan (2010: 170), an American who volunteered in an orphanage in Kathmandu and then went to Humla in search of the orphans’ families, provides us with his initial impressions of the district after walking just a few hours south of Simikot:

I would not survive one day here alone...it took days to get anywhere. Poverty was everywhere; most villagers were fed by the World Food Programme. There was no electricity, and houses were one-room mud huts. There was virtually no medicine: the health posts had been abandoned. If villagers had to move around at night, they lit their way using flaming torches, like they were hunting Frankenstein. I didn’t know these places still existed.

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<sup>71</sup> These exceptions include a “Karnali Highway” that treacherously connects a portion of lower Jumla to the road leading to Surkhet, which has also made some forays into Kalikot district. In addition, there is an impressive bit cut from Purang (Taklakot) in Tibet over Lalung La down to Tungling in Humla’s Limi VDC. This has been accomplished with the organization and hard work of the communities of Limi; I imagine, much to the chagrin of the UN WFP and its partnering NGOs, who have been sponsoring a road project for more than 15 years in an attempt to connect Simikot, Humla’s district headquarters, to Hilsa, the expanding market settlement right on the border with Tibet.

Perhaps descriptions such as these are unavoidable, since they are—in some ways—not entirely untrue. But, if how you are represented is how you are treated, to paraphrase Stuart Hall,<sup>72</sup> then how might representations of impoverished people living in breathtaking places structure the imaginations and interactions of foreigners who come to ‘do good’ or help? This is a topic I take this up in the next chapter, and throughout this dissertation.

In many ways, this dissertation examines people and events that come and go, leaving traces and afterlives in their wake. But, what of everyday life, which is not fleeting, but often slow and time-consuming, arduous but beautiful? Like many places that anthropologists are privileged to experience through extended field stays, I do not expect to be able to convey with any commensurability the way life *truly* is in Humla, nor for that matter do I propose to know such a Humla beyond my own partial experiences there. I am keenly aware—perhaps now more than ever as I attempt to bring you, the reader, with me—that sights, smells, and sounds do not transcend paper or computer screens. Photos help, but they, too, fall short. Nevertheless, I’d like to offer a glimpse of life when there are no medical volunteers present, and when people are not queuing for health camps or to purchase subsidized food aid rice. What of the long-standing rhythms and textures of daily life that endure in much the same ways that they have for decades? Much of this will emerge in the ethnographic discussions that follow. However, in this chapter, I’d like to attempt to describe some other parts of this life, that which we cannot glean from the scholarship and stories in the rest of the chapters that follow, and without which the chapters that follow would lack important context.

### **Simikot, a Changing Mountain Town**

With no roads connecting the district to the rest of the country, there are only two ways to get to Humla: walking for anywhere from several days to two weeks, depending on your point of entry, or flying to Simikot in a helicopter or plane. Those who go to Humla—trekkers, reporters, development workers, sometimes politicians or other urban elite—arrive by air. I know this ride well; a (literally) breathtaking forty-minute ride in a non-pressurized, seventeen-seat Twin Otter

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<sup>72</sup> I am thankful to Rachel Chapman for introducing me to this quote, and for helping me to see that we might also come to think of the practices and politics surrounding ethnography as firmly ensconced in the idea of power as representation.

prop plane that takes off noisily from the Nepalganj airport along the Indian border. The journey spans the entire North-South breadth of Nepal, and as the non-pressurized plane climbs, the agricultural plots below grow smaller and smaller, and they are noticeable for their lush colors but also for their lopsided, jagged or round shapes, so distinct from the squares of monocropping I readily associate with food production in the United States.

Flying over the Bheri River, one of the Karnali River's major tributaries that drains the western Dhaulagiri range, the Tarai plains give way to the inner, forested Chure hills of the Siwalik region, which slowly rise to form the green bumps of Nepal's mid hills. Cliffs and ridges over Dailekh district become visible below, and I can make out the sheer precipices and ridged slopes of Kalikot shortly after, out of which agricultural terraces and pastures are meticulously carved over every cultivable spot. The famed Rara Lake of Mugu district is visible off to the right of the plane, and then the 7000meter Mt. Saipal—the biggest in western Nepal—off to the left, signaling my arrival to upper Karnali. In some places the plane is no more than a few hundred meters above the edges, and crests peak out of the cloud wisps so close you feel you can touch them. It's now only a matter of minutes before the plane begins to quickly careen downwards over a 4000meter pass into the district of Humla. I feel safe in the plane as long as I sense calm among the pilots, who hone in expertly on the airstrip (constructed in 1982 and paved in 2011) perched precariously on a ledge roughly 1000meters above the Humla Karnali River. At the edge of the rain shadows of the Tibetan plateau, weather is unpredictable in the region, particularly during the monsoon season (early June through the end of September). It is not uncommon for flights to take several sweeping passes over the airstrip before mountain fog and haze clears long enough for police to remove grazing cows and small crowds of young and old men seated on the ground in circles playing cards from the airstrip. When they do, with a loudening rumble and an always-bumpy touchdown, the plane reaches Nepal's most geographically remote district.

From a hilltop perspective, you can discern rather well the social geography of Simikot, a small mountain town populated by only several thousand of the roughly 45,000 residents that live in the district. Until the 1970s, Simikot was largely agricultural land and pastures worked and grazed by two main Hindu (Khas) Chhetri villages and several clusters of lower caste artisans situated to the northwest and east of the airstrip. At the time, there were only a few government buildings for administration, a large health post (later turned into the district

hospital), and a Nepali army camp, built on top of the last protected forest hilltop (*Rāniban*) that overlooks Simikot. Now home to roughly 200 soldiers, the site was an ancient fort (Nepali: *kot*) that overlooked a once-large marshy area (Nepali: *simi*), which is now the site of a private, NGO-run hospital (Figure 3.1).



**Figure 3.1** Simikot, the district headquarters of Humla, with newly paved airstrip that divides the small mountain town between the administrative buildings and compounds to the south, and shops, restaurants, hotels and new houses to the north of the strip. One of the old Hindu (Khas) Chhetri villages is easily identifiable at the furthest eastern (left) part of the photo. Source: <http://patagoniandreams.com/tag/humla/>

In recent decades, and since the collapse of the ancient grain-salt trading caravan (discussed in chapter six), Simikot has grown much bigger. It is the district's center of commerce and home to a growing number of teashops, general stores, tailors, restaurants and hotels, which provide basic

accommodations and meals for the steady stream of people who come in and out of the town for various purposes. Humlis who live in or nearby to Simikot walk through the district headquarters to sell bundles of freshly chopped wood, giant heads of cauliflower, seasonal apples from their orchards, mushrooms foraged from the woods. People weigh these goods in scales hung from their doorframes, and they haggle in what—to my overly polite western ear—sounds like harsh tones over the price per kilo. Some Humlis have made the arduous walk to take their chances at the district hospital, uncertain about so much: if a doctor will be present, or how other government health care workers will treat them upon their arrival; or if they will be told they are sick and have to stay in the hospital for days they cannot afford in agricultural labor time, or buy medicines they cannot afford in rupees. Humlis also come to attend health camps at this hospital compound, or to buy food aid at the NFC food depot, as I discuss in chapter five and six, respectively. But, they stand in other lines, too, hoping to collect free seeds as part of a welfare program operated by the local District Agriculture and Development Office, or to buy fertilizers and, increasingly, pesticides flown up from the Indian border. People conduct other administrative tasks in government offices, visit with friends and relatives, and purchase, barter, or sell other basic commodities and foodstuff. Many have come to do a combination of all of these activities, as agro-pastoral schedules in Humla are stringent, and some Humlis may only have time to make a trip to Simikot once or twice per year.

Nearly all of these goods available in Simikot are flown up from Nepalganj or Surkhet in the Tarai, or carried down from Tibetan markets on the backs of people or small caravans of sheep and goats, horses, or cow-yak hybrids. Their loads unsaddled for a night's rest, some of these animals rest in herds, or wander through the streets munching on dust-covered vegetation or sometimes still-smoldering garbage piles of papers, cardboard and food scraps. Barefoot and pantless children pause from pantomimed cricket or volleyball games to climb on animals, and throw rocks or kick them and beat them with sticks, though not in a mean way, laughing and sniffing up their dangling snot strands all the while. Sometimes the animals' owners come out and chase the meddlesome kids away, but more often they can be found behind the hanging curtain doors of the small hotels. Inside, groups of (almost always men) travelers relax from days-long journeys, drink cheap Chinese whiskey, steaming tea, or home-brewed *raksi*, and eat huge helpings of *dāl bhāt*, freshly steamed *momos* (Tibetan dumplings), or bowls of instant noodles colloquially called *chow-chow*. After meals, some wary travelers indulge in snuff or lip

tobacco called *khaini*, and many pass around cigarettes or *sulpā*—local chillum-like pipes used for tobacco—as they share stories of their movements, inquire about one another’s crop yields, talk about families and shared relations, and catch up on other notable news. It is not uncommon for elder Humlis (mostly Hindu) to speak in local vernacular metrics of time and movement, such as measuring the distance they travel throughout the district in the number of *sulpā* one will smoke during the course of their journeys. An elderly Khas Chhetri once asked me, as we sat together taking a snack of momos and tea at a small table inside one of these shops, how many *sulpā* it took to reach my home in the United States. I began to explain that it would not be possible to count the number of *sulpā* because of the ocean that lay in between us, making walking impossible. Soon we were sidetracked by a discussion of blue whales—the “giant fish” that I thought might be useful to help explain the ocean. I was told that I was making up nonsense when I explained about oceans and how these fish were the size of half the airport runway. The differences between this world and my world—“here” and “there”—are revealed in so many moments like these.



**Figure 3.2** A growing number of shops in Simikot sell basic goods that are flown up from the Tarai, or trekked down from Tibetan markets across Nepal’s north-western most border.

There are no cars or bicycles in Simikot, though several tractors and plows were helicoptered in to begin work on paving the airstrip in 2009. In the early months after their first arrival, large groups would gather by the side of the runway to watch them drive up and down, flattening earth, toting rocks. Beginning in the early 1990s, hydro-electric power and a huge strip of solar panels north of the main bazar began to provide electricity to Simikot, which now has working power for nearly twenty hours per day; an ironic contrast to Kathmandu and other urban, more populated places in Nepal that often experience up to eighteen hours of load-shedding (scheduled power cuts). In the past few years, the government has also been working with several private companies to bring the technological infrastructure for television, internet, and mobile phones to Humla. Many Humlis have begun to purchase phones and the scratch off cards used to charge ten, twenty, sixty minutes of calls; but more often phones are used to play folk songs, tucked away in people's pockets as they walk the trails throughout the district. Amazingly, several "internet cafés" have cropped up in Simikot, and towards the end of my most recent nine-month stay in 2010, I was able to periodically check my email and receive Skype phone calls from family and friends on an unlocked mobile phone I had purchased in Kathmandu. I would try to describe to them the view out the window of the small and cozy room I would rent in a guesthouse operated by the NGO with which I first went to volunteer in Humla in 2004.



**Figure 3.3** A newly constructed shared home and NGO office in Simikot.

For an area so remote, the presence of Humla’s nongovernmental government can be glimpsed in these tin roofs—“the sign of wealth,” according to my friend and research assistant Puja. NGOs in Simikot are identifiable as the newly constructed building made out of rocks painstakingly put together to form perfect puzzled walls (Figure 3.3). These NGO-homes also double as homes for staff or their family members. As of 2010, there were 177 NGOs registered with the local District Development Committee (DDC) office—roughly one for every 270 people in the district.<sup>73</sup> The most recently published *NGO Profile of Humla District* booklet I was able to collect (2063 v.s. [2007]: 12-14) listed 106 DDC-registered NGOs, with 49 (46%) of them reporting work in the health sector, and 30 (28%) working in agricultural development. Yet, the district ranks consistently at or near the bottom in most health and socio-economic indicators such as child mortality, chronic under-nourishment, and per capita food production (Table 1.1 chapter two). Some of the signs of NGOs in Humla read: “The Empowerment Society for Rural Development” (*GrāhmiN Bikās kā lāgi SashaktikaraN Samāj*), “The Social Committee for Health and Development,” (*Bikās ra Swāsthya ko lāgi Samāj Samiti*), or the “Rural People’s

<sup>73</sup> Only a handful of these organizations are consistently active, and sometimes NGOs will register multiple times for a range of different inter-organizational projects.

Upliftment Development Program” (*GrāhmiN Janā Utthān Bikās Karyākram*). These signs hang over doors that remain habitually padlocked, which is symbolic of the imagined futures and improved lives that these organizations purport to bring, yet remain locked away from most Humlis.

### **Out into the *GāuN* (Village)**

There are three major paths that lead out of Simikot. One leads north towards Tibet. Another leads south to the lower hill valleys of Humla. And a third leads east along an outlying ridge before winding around a sheer hillside into Nyimba (*Nhinyul*) valley,<sup>74</sup> situated beneath the holy Mt. Shelmogang (Crystal Peak), one of the twenty-one peaks that circumscribe Mt. Kailāsh to form a scared mandala of mountains. High above the five main villages of Nyimba (four Buddhist and one Khasa Chhetri), at the base of Mt. Shelmogang is believed to be the siddhi cave of Guru Rinpoche, beside which a monastery called Raling *gompa* (a Tibetan monastery) was constructed. For Nepal, this is also an historic site, as it was the location where the oldest *tāmrapatra* (official orders chiseled on copper or clay plates to record land grants and religious donations) written in Khasa language was found, and from which much of the ancient Karnali region’s history is gleaned. Raling remains a holy pilgrimage sight for Hindus, Buddhists, and *dhāmi*, and many Buddhist villagers still prostrate their way for several days to reach the monastery. Once a year during the full moon of the Nepali month of *Jeth* (May/June), the people of Nyimba valley honor the Lord Buddha’s birthday and moment of enlightenment by circumambulating the *gompa*, and perform traditional songs and dance that revere local gods, Bodhisattvas, and other Buddhist deities of the Nyingmapa sect.

I was lucky enough to observe this festival in 2010. Attendees came dressed in their best clothes and wore their finest ornaments, including gold pendants and coral and turquoise jewelry, passed down from generations. Families sit on the giant lichen-covered limestone boulders that surround the monastery, relating stories from the year as they share spiced radishes and potatoes, buckwheat pancakes, *tsampa* (roasted barley flour), hot butter tea, fresh yak milk, and home-

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<sup>74</sup> See Levine (1987) for a rich ethnography of the Nyimba valley. See Kapstein (1997) and Lama (2002: 55-62) for detailed discussions of the sacred Mt. Kailāsh mandala.

brewed *chāng* (home-brewed ‘rice beer’). At the end of the second day of the festival, all participants walk down from the *gompa* to a site for ritualized call and response circle dance known as *Shon*, performed by the light of the full moon and the embers of burning tree stumps. With arms wrapped around one another, groups from different villages face each other and move slowly in a counter-clockwise direction, swaying back and forth. Participants sing words based on traditional stories of ancient mythological heroes and foes, and improvise them to sanctify and celebrate their toil as farmers, agro-pastoralists, and mobile traders, whose rhythms of everyday life in Humla all begin early again the next day after an up-all-night festival of song, drink, feast, and dance.

Another path leading out of Simikot climbs steeply in switchback fashion up a gravelly hill past the Simikot central water tap, a multi-tiered construction of ancient stone and newer concrete. Throughout the day women and girls clean dishes, fill water containers, and bathe skillfully in cloth *lungi* wrapped around their bodies. My eyes remain trained down at my boots as I continue up the path that leads above and beyond the army encampment, heading northwest along a five-day trail that follows the Karnali River and eventually meets the border with Tibet. No matter how long I’ve been in Simikot, I must pause on this initial climb because of the difficulty of breathing at this altitude. Leaning forward to rest on my walking stick, I hear the screams of children playing at the hilltop school, and the brays of mules that rise echoing up to the 11,000foot pass that leads northwest beyond the district headquarters. My new surroundings are sweet-smelling pine and juniper forests, patches of rhododendron shrubs, and azalea. Heading upwards, cultivated patches of barley, wheat and some scattered amaranth are enclosed by walls of carefully layered stone. One can’t help but marvel at the brown, green and gold crop colors during the Nepali month of *Kartik*, my October, right before one of the three main harvest cycles in Humla at this elevation. Terraced slopes give way to shaded green and brown escarpments that eventually fade up into white frosted peaks in a clear blue sky.



**Figure 3.4** One last view of Simikot before heading north along the Karnali River trail, that leads to Nepal’s northern most border with Tibet. Mt. Shemlogang (Crystal Peak) is visible to the far left.

Walking north along the Karnali river, small teashops of stone and wood dot the trail in growing numbers, offering limited foodstuffs to people on the move—mobile travelers, traders, and foreign trekkers—who take breaks here. Humlis rest heavy loads that they carry using a head strap called a *nāmlo* made from strong fibers (e.g., jute, nettle [*allo*], bark, bamboo). Visitors in the teashop eat *dāl bhāt*, instant noodles and sip cups of steaming *chiyā* (Nepali: “tea,” often prepared with sugar and milk), *raksi*, or *chāng*. Men share cigarettes as they let their pack animals graze within sight; squatted close to the earth, arms tight by their sides, feet flat on the ground with butts touching the back of their shoes, they pass the cigarette back and forth until it is gone, and then set off to round up their animals and re-re-ready their loads for the trail. Over time, my body would also come to reflexively adopt this positions; around a hearth, by the side of a river washing my face.

The river trail continues to wind north up steep rocky slopes in places where the river is confined by narrow cliff walls. Packs of grey langur (*Semnopithecus schistaceus*) and rhesus (*Macaca mulatta*) monkeys scamper expertly up and down these steep inclines, periodically making forays to outlying village crop plots before young children sent to guard them notice, and begin launching stones and shouting. Log bridges point the way over streams that wind through hushed forests and then emerge again to reveal vast, open mountain valleys, on the sides of which are villages of<sup>75</sup> various sizes and ethnic composition. Ancient Masta shrines as well as Buddhist *chorten* dot the trails, a reminder of the hybrid religious practices that endure in Karnali and continue to stand as forms of cultural resistance to the high caste Hindu dominated Nepali state.

One day north of Simikot, one encounters only Tibetan speaking Buddhist villages. For the ease of Nepali governmental census and survey procedures, all these Buddhist villagers have been given the last name (which serves as their ascribed caste) “Lama,” which both distorts the diverse languages, histories, and religious-cultural traditions of these groups and usurps the true meaning of the revered Tibetan masters/healers/teachers known as Lama (Dorjee 2009).

Until the most recent decade or two, these Buddhist communities practiced fraternal polyandry—the marriage of one woman to two or more brothers, though only those from the same or nearby villages. This system served as a major guiding force in village political organization. It also conserved resources in settings of scarcity, enabled fraternal solidarity, and allowed for a rotating and staggered division of labor among multiple adults to support the

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<sup>75</sup> These ethnically “Mongoloid” groups are commonly referred to in the ethnological and social scientific literature as *Bhotiya* or *Bhotey*. The term “Bhot” comes from the late Sanskrit Bhotah, which derives from Bod, the Tibetan word for Tibet (see Charles Rambles discussion, cited in Lama 1993). These terms are often used pejoratively, especially by high-caste Hindus, as they also connote socio-cultural practices frowned upon, such as alcohol drinking and the consumption of beef (or yaks and cow-yak hybrids). *Kirānti*, from the Sanskrit *kirāta*, is another name used in classical Indian texts to refer more broadly to the Tibeto-Burmese hill peoples of the Himalayas (Whelpton 2005: 13), and which Slusser (1982) writes carries the meaning “to roam on the edge” (as cited in Bishop 1990: 68, fn. 3). Here, similar to the term *pahāDi*, we see how the agro-economic niches and relational identities that spring from them serve to create ethnic divisions, so that “what begins as the term for a location or a subsistence pattern comes to represent ethnicity” (Scott 2009: 261). In general, *kirānti* is used more frequently to refer to the ethnically Tibeto-Burmese groups in eastern Nepal, such as the Rais or Limbus, while, in my experience, the groups in Karnali are referred to as “Lama” communities or, more derogatorily, *jād*. In Humla, every ethnically Tibetan person shares the surname Lama, though on official census and cadastral documents are given—incorrectly, and seemingly for the sole purpose of convenience—the last name Tamang. Levine (1987: 80) documents the transition over the course of her fieldwork in Karnali, writing that, in under just one decade from 1973 to 1982, all Tibetan speakers she encountered in Humla were referring to themselves as Lama or Gurung, both of which are perceived to be more prestigious than Tamang. This “ethnic metamorphosis,” she writes, occurs to give Tibetan communities “labels relevant principally for national political and legal systems.”

specialized agro-pastoral and trade based household economy that Humla demands of its inhabitants (Levine 1988). Over the years, these Buddhist communities have by and large stopped the practice of polyandry. Young people now typically practice monogamy, which has reduced the size of land holdings passed down along patrilineal lines, causing families to divide agricultural plots according to the number of sons in the family. Along with a decrease in youth interest in farming, this land fragmentation has contributed to changing foodways (and perhaps food shortages) in Humla.

However, these Buddhist communities have continued to make strategic use of their proximity to the border and the ancient trading markets of Taklakot, and now engage more in selling planks of timber, wooden bowls called *phuru*, and a range of *jaDibuti*, such as *attis*, *katuki*, *pāNchauli* and *yartsagunbu*—a “caterpillar fungus” (translated from Tibetan as “summer grass, winter worm”) that is believed to possess aphrodisiacal qualities.<sup>76</sup> *Yartsagunbu* (also called *jeevanbuti*, or ‘life root’ by Humlis, or “the Himalayan Viagra” in popular media) can fetch anywhere from \$USD 3,000-6,000 per kilo, which is of course a lot of dried worm-mushrooms. During certain months, entire villages that live in parts of Humla where it is known to grow will establish temporary camps on the ridgeline and search for this valuable commodity.

The third major path leading out of Simikot heads south and immediately descends 1000meters to reach the confluence of the Karnali and the Chumsa Rivers, and a different geo-climatic zone all together. The kinds of trees and plants differ from the juniper and pine forests up north, and more resemble the giant agave and xerophytic plants found throughout Central and South America. Here, one encounters Thakuri and Khas Chhetri Hindu villages, which are more condensed and densely populated than Tibetan-speaking Buddhist communities in northern Humla. Khas Chhetri kinship ties are often defined by *thar*, which, according to Bishop (1990: 96) is a “Brahmanical refinement or ordering of the tribal clan.” Villages have continued to adapt kinship ties over time. For example, the Thakuri people living in Gothi in southern Humla, differentiate households according to a system of patrilineal descent through one’s *paTTi*, which is similar to a *thar*, but based in one of five traceable familial lineages.<sup>77</sup> Unlike Buddhist communities, prospective marriage arrangements span great distances, though rarely cross *thar*.

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<sup>76</sup> *Yartsagunbu* is a fungus [*Cordyceps sinensis*] that parasitizes the larvae of certain Himalayan moths (e.g., *Thitarodes* (*Hepialus*)). See Winkler (2008a, 2008b) for a fascinating discussion of this the emergence of this new non-timber forest product (NTFP) as an important new source of income for Tibetans, or what he calls the “Fungal Commodification of Tibet’s Rural Economy.”

<sup>77</sup> These are *GaTalā*, *Pārapatti*, *Dhāmipatti*, *Talapatti*, and *Naikpatti*.

Polygyny—the marriage of one man to two or more women—was sometimes practiced among the Thakuri and Chhetri, though it is rare today.

With slight variation, Hindu and Buddhist houses in Humla are both constructed from a mixture of wood, some stone, and compacted earth, and are often built into hillside slopes in cascading ascension on top of one another leaving narrow, winding walkways below and between. Homes typically consist of three stories that people access with moveable carved, wooden ladders. If a family has animals—and most have at least some—the lower level houses them, with their collective body warmth and heat from their waste rising. The second story is the main living area, with small bedrooms, storage rooms, and a kitchen, where families gather for meals around a closely tended fire, which were traditionally built in open hearths, but nowadays are housed in iron smokeless stoves (Nepali: *chulo*) that are purchased by the family if they can afford it, or brought by NGOs working in the region. The stone walls of most kitchens remain black with the residue of *jhāro* (N), a high-resin pine that burns slowly and brightly and, up until the past ten or fifteen years, was a primary source of light in the dark. While *jhāro* is sometimes still used, NGO-installed solar panels now power one or two light bulbs in most homes, and people carry flashlights.

The top floor of homes may have other rooms, such as storage space for horse riding equipment or, with the case of Buddhist homes, a prayer room that contains a family's statues and prayer books, many having come from Tibet in the mid twentieth century. In the 1950s, as Tibet was brutally incorporated into China, families fled in vast numbers over the mountain passes into Humla, selling their possessions to lighten their loads, gain some money, and ensure the safety of these venerable relics with other Buddhist groups.

Most important is the home's flat rooftop, which is carefully layered to deter leaks with straw, tree birch, stone and mud. It is used for social purposes like conducting meetings or other gatherings, to call to people working in the fields, and to perform the crucial tasks of processing grains, and drying clothes, crops, and animal skins. On the roof, men shave with straight razors, looking in a mirror fitted craftily into a notch in a supporting beam. Women splay their long hair after bathing, and braid it or the hair of a daughter or neighbor, sometimes applying a few drops of freshly heated peach oil before combing it through. The rolls of naked baby arms and legs are also warmed in the sun on the roof, and then massaged with the leftover oil.



**Figure 3.5** A Thakuri village in southern Humla.

The roof is also a place for expressing anger over misfortune, or diffusing social conflict between neighbors, even when one does not know which neighbor is deserving of the admonishment, as I witnessed one evening under the moon with my research assistant Subash. We were on our way to Subash's home village in southern Humla and stopped to stay with some of his relatives in a village on the way. The festival of *Dasāin* was approaching, and people were extra busy in the fields, washing clothes, or searching for a goat to ritually slaughter and eat, if it could be afforded. Only a few hours before, Subash had been trying to describe to me the local custom of yelling from the rooftops, when we suddenly heard the outcry of an old man. We could see him standing at the edge of the roof two houses away, yelling up and into the moonlight. After a few initial yells, Subash told me that his dog had been killed: "What did my dog do?! Did it enter your fields? Did it eat something? Why did you kill my dog?! Why did you kill my dog, you bastard?!" The old man then began to levy curses against the ostensible suspect, wishing ill on

them and their family, but knowing that—because the person is never known or named—the misfortune will never befall them: “May your children not celebrate *Dasāin!*” he yelled. “May monkeys come and eat your crops! May a boulder fall on your crops! May you be cursed by the gods of the holy *MāRnu* shrines in Chipra, Chala, and Mt. Kailiāsh.” This continued ten to fifteen more minutes, until the man was satisfied, or was out of breathe, and then he climbed down a ladder out of sight. While these verbal projections are indeed harsh, they are hollow and aimless. In places where misfortune of all kinds—sickness, death, infertility, crop disease—are believed to be caused by witches, ghosts, or other evil spirits, there is no need in such precarious living situations to get into actual fights with your neighbors if they can be avoided.

Other sounds of village life begin early before sunrise, before the rooster calls out. I often rise to the metrical thumping of women and young girls pounding grains in the hollowed out holes made over the years in boulders centrally located in the village. Women and young girls—if they are not in school (and most are not)—are busy all day long involved in the everyday tasks of social reproduction. This work is enervating and thankless. Swaddled in cloth on their back, women carry around all day long babies they either delivered themselves in the fields or at home with the help of other women. They squat expertly beside a buffalo that will only milk to the touch of their calloused hands and the sounds of their voice. With rolled up pant legs, hunched over low to the ground, women wade into the mud to transplant rice seedlings at the right time of the season. They spread dung fertilizer in the fields and weed them several times a year. They fetch water from central taps or sometimes-far-off streams in huge clay vessels, and then place them in *dhoko*—sturdy, bell-shaped baskets woven from lattice bamboo—which they carry on their forehead using the *nāmlō* strap. They sit and sift rocks from grains using woven bamboo trays called *nānglo*. Holding with two hands, they swiftly bring the tray down, suspending grains in mid air as if in a freeze frame, before expertly catching every one again.



**Figure 3.6** A young girl pounds millet in a timeworn boulder located centrally in a village.

Men have more free time on their hands, though their days are arduous nonetheless, participating in daily work in the fields and at home. Men stand behind plows and drive forward oxen or buffalo to turn earth or dig planting channels. They split and carry firewood, construct bee boxes of pine, weave bamboo baskets, make fishing traps, and spin animal wool on wooden spindles endlessly throughout the day, so that their wives can weave thick blankets called *liyu*. They walk to Hilsa and Taklakot to trade and buy goods such as alcohol, Chinese-made shoes, and other commodities sold in teashops and in Simikot.

Elders often dwell around the home, assisting in the tasks they still can, sometimes instructing others on how to do their work more accurately. They carry grand- or great-grandchildren on their backs, help women chase chickens away from drying grains, and watch from rooftops the activities of the village. Buddhist elders sit and pray, moving their thumbs effortlessly and expertly over prayer beads or spinning prayer wheels as they chant, ‘*Om mani padme hum*,’ the mantra of the Buddha of compassion, translated most frequently as ‘Praise to the jewel in the lotus,’ as they prepare for the next life.

## CHAPTER FOUR

### Examining the Circulations of Short-Term Medical Volunteers in Nepal

*I wanted to look at what volunteers did in a completely different light...I wanted to point out the damage in volunteerism, the damage to the person who goes there—a sense of superiority, establishment of the savior complex to the people down there, and to the image of what poor countries are...An image now, not only dependent on journalists, but on people who claim that they report with much more knowledge of local situations, in the light of these people needing us.*

~ Ivan Illich, *A Question of Witness* (cited in Cayley 1992: 94)

*Hāmi garibi lāi u yahāN yasto Thulo doctor lāi bhagwān le pathāya* (For us poor people out here, these big doctors are sent from God).

~ Tsedup Sangmo Lama, forty-three year old mother of three, after receiving vitamins and antacid tablets from a foreign volunteer

### Healing Shangri-La? From Missionaries to Medical Voluntourists

Nepal has become a popular destination for short-term medical volunteer work, a burgeoning form of modern medical travel that involves short-term, voluntary health care stints, training or service initiatives in poor countries by students, tourists, or clinical professionals from wealthy countries. As discussed in the first chapter, there is increasing debate surrounding the ethics, benefits, and limitations of short-term international medical trips, though it has not yet become ‘taken-for-granted’ enough to assume that these are widely known. Therefore, in this chapter I also examine some of the potential unintended consequences of this work, specifically as they relate to local health care delivery. Beyond this, I expand the debate by taking a slightly unconventional approach to exploring this phenomenon by looking at how *bideshi* (Nepali: foreign) medical volunteers circulate as one form of short-term care with their own active but ambiguous social lives. Volunteers become part of the new “global health care chains” (Nichter 2008a: 173), acting act as one kind of “medicine in export” (Wendland 2010: 8) from wealthier nations. In this process, medical aid and those who bring it become a commodity that also “flows” in and out of places, becoming associated with a constellation of values, meanings, and

uses. In this chapter, I examine the experiences, traces, and (after)lives of this increasingly popular and problematic model of short-term care—what I have called medical voluntourism (Citrin 2010). I show how, through these circulations, the temporary presence of medical volunteers over time contributes to the (re)shaping of local ideas and practices surrounding health and medicine(s) in Humla. I also highlight how medical volunteers become mobile markers of inequalities—global and local, medical and material—while simultaneously accumulating the social capital of a “global health experience” (cf. Brada 2011) that benefits them personally and professionally.

My first visit to Nepal in 2000 was not as a medical voluntourist, but as a bachelor’s student pursuing a degree in anthropology. In fact, I became interested in anthropology because of the mystical allure of the Himalayas, a place I had always longed to go. Big, snow-capped, mountain chains burst onto a pull-down projector screen in the first anthropology class I ever took in college. These mountains not only seemed to offer me the Shangri-La-like experience I was after, they also promised to take me as far away from my mother who, at the time, was slowly fading from early onset Alzheimer’s disease. As she became nearly unrecognizable to me, I became lost to her. The “almost impossible coherence” (Cohen 1998: 14) of her illness’s progression left me feeling isolated and alone, despite an incredible support network of family and friends. Nepal represented a distance that I sought from the painful reality of my family life transformed through illness.

As Arthur Kleinman (1988: 8-9) notes, “illness experiences and events usually radiate (or conceal) more than one meaning...Powerful emotions attach to these meanings, as do powerful interests.” With my new interests in illness and healing, I went to Nepal on a study abroad trip for the proposed academic purpose of exploring shamanism as a locally affirmed medical system, and to see how Buddhist conceptualizations of suffering acted as an explanatory model through which faith healers and local people approached misfortune and curing. But, I also went to Nepal to escape from missing my mother, from forgetting her, and from being forgotten. I was in search of my own healing.

I remember my first landing in Kathmandu. It was night, during scheduled load shedding hours, and I drove through the streets of the city dimly lit by candles, which revealed in the flickers packs of roaming dogs, butchered meat hanging and splayed out for sale by the side of the road, and huge piles of trash being picked through by cows and goats. Beyond the streets, I

could make out improvised squatter settlements in open fields and along the holy Baghmati River, considered to be one of the most sacred water sources for Hindus, but also one of the most contaminated rivers in the world. I saw how, even in Kathmandu, people struggled to secure livelihoods. I also began to read in the newspapers each morning about the atrocities of the Maoist conflict outside the capital—the open killings and beatings of political leaders, and the sexual abuse, beheadings, and disappearances of Nepali villagers caught in the crossfire of the conflict. I was horrified and humbled, and a bit confused. I became struck by the feeling that the Nepali writer and scholar Manjushree Thapa (2005: 3) eludes to in her book *Forget Kathmandu: An Elegy for Democracy*—that “the last anyone knew, Nepal was a pre-political idyll, a Himalayan Shangri-La good for trekking, mountaineering, and budget mysticism,” but that now that mythical place may be changed forever, or vanished.

That first trip was a profoundly transformative experience; it changed everything for me—my politics and worldviews, my sense and scales of relative wealth and poverty, of wellbeing, healing, and suffering. I still ached over losing my mother, but my otherwise privileged, middle class upbringing in suburban New Jersey—for which I am ineffably grateful—was quickly thrown into sharp relief, rendering it both arbitrary and incomprehensible in a newly exposed world of vast inequalities. Since the day I left Nepal that first time, I knew I wanted to go back; but also to give back, to a place that gave me so much in terms of a personal awakening. This feeling of having been partly “healed” of my own suffering, or in some other way transformed by experiencing Nepal, is a common theme in the trajectories of those who come searching in the Himalayas, either on journeys to heal themselves or to heal others. Indeed, as Mark Liechty (2005: 26) notes, how people imagine Nepal differently over time has created different kinds of tourists, tourisms, and even different kinds of Nepal. The imaginings of medical voluntourists seeking a Shangri-La to heal is no different, and thus these imaginings therefore deserve special attention as an affect that structures ongoing relationships that visitors have with the Nepal. Liechty asks questions relevant to an analysis of medical voluntourism: How are these “spatial imaginaries” formed? How do they promote and shape touristic desires? And, how do these imaginaries impact their destinations?

Circulated representations of Nepal play a part in these processes. Similar to the online advertisement that first caught my attention when I was searching for a way to return to Nepal, I recently found this announcement (below) on the website *Idealist.org* seeking medical volunteers

for ongoing health camps in one of the country's remote districts. It is worth quoting at length, as it provides greater context for this chapter, which examines the movements and meanings associated with the growing number of medical volunteers who come through university electives or private NGO-affiliated volunteer programs, often without understanding the potential implications of their presence and practices. The ad also offers a glimpse at how representations of health and health seeking patterns acquire their own social lives. Here, we must take seriously Mark Nichter's (2008) proposal that cultural perceptions and social representations are crucial to the increasingly biopolitical ideologies and interventions of global health. For remote mountainous regions of Nepal—and for Humla in particular—the social life of these representations are enduring, simultaneously productive and reductive, and used to both perpetuate a need for a certain kind of short-term intervention and attract a continuous stream of medical volunteers. The announcement reads:

Many rural Nepali people are often reluctant to go to the hospital and other modern health services because of orthodox thinking, superstition and other cultural influences. Some Nepali people may visit a witchdoctor when they are suffering from an illness, so they sometimes die as a result of avoiding modern medications. By living and working with rural communities, volunteers also increase the exposure of rural Nepali people to modern medicine.

Health camps are located in the mountainous and/or rural regions of Nepal. Volunteers live for one to two weeks in the same manner as the Nepali people. The participants camp in tents near the clinic and eat traditional food cooked by Nepali cooks. As this program will be organized in rural areas of Nepal, this program would give volunteers the opportunity to experience the rich culture, natural splendor, panoramic views, short treks and daily life of one of the most beautiful yet poorest nations in the world, and at the same time experience life in Nepal first-hand, working alongside Nepali people to help support local communities in Nepal. If anyone is interested in joining this programme they may work in the permanent clinics in Kathmandu or in rural settings. Volunteers may choose a term of service ranging from one week to 2 months. Whilst we would prefer volunteers with medical experience, *anyone interested in healthcare is invited to apply* for this programme (my italics).

There are a number of things to unpack in this depiction of a people, a place, and a program. Firstly, this sweeping and reductive social representation of Nepali people strategically deploys the trope of orthodox and superstitious culture both as something to overcome, and as a social fact to justify this form of short-term medical intervention (Nichter 2008a: 5; see also Wendland

2012: 10). Missing from the description above are the various and sophisticated ethnomedical systems in Nepal, where a plural syncretism of traditional, folk, and professional forms of healing—including biomedicine—has long been common. Also absent is any mention of the social, cultural and political economic factors that influence health and healing, such as gender, class, caste, stigma, poverty, and war. To this list we can now add short-term medical volunteers, whose continued presence also informs these local decisions and practices, as I show below.

Secondly, the invitation for “anyone interested in healthcare” is cause for concern over the potential for medical harm. As Roberts (2006: 1492) notes, the use of untrained volunteers to deliver medical care and medications is not allowed in rich countries, and so it should not be allowed elsewhere. She argues that despite the good intentions that inspire many to do this work, such “duffle bag medicine” can put people’s lives in danger while simultaneously avoiding basic public health and preventive measures. This point resonates deeply with me, as I think of the countless pills I passed along to attendees while volunteering in health camp dispensaries. The most frequently heard question as I did so was, “*Kasari khāne yo*”? (How do I eat [take] this?) As I show below, medical volunteers also share similar concerns about the use and misuse of medicine in areas where the most basic human needs are unmet.

Thirdly, the representation of Nepal above capitalizes on and perpetuates a discursive tension that has long been common in the Himalayas: that between beauty and poverty, between Shangri-La and Least Developed Country (LDC).<sup>78</sup> In development discourse, a LDC is a ‘comically generic’ representation of a country with all the right developmental deficiencies and mostly poor inhabitants (Ferguson 1994: 70) required for intervention. Indeed, the anthropologist James Ferguson has noted how reports written on the developmental challenges of Lesotho “look as though they would work nearly as well with the word ‘Nepal’ systematically substituted for ‘Lesotho.’”

And, if Nepal has all the right developmental deficiencies needed for intervention, it also has an added bonus: beautiful mountain scenery that lends itself to the mythical descriptions of Shangri-La. The idea of Nepal as a mythical Shangri-La has a long history and is frequently invoked in development and volunteer writings about Nepal (Holmuest 2002: 128; Jackson 2008;

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<sup>78</sup> I am thankful to Jane Dyson for first bringing this Shangri-La/LDC discursive tension to light (personal communication, 2006).

McKersie 2005: ix). For enlightenment seekers, trekkers,<sup>79</sup> developers, and medical voluntourists alike, the country has long played host to the imaginations of fans of James Hilton's 1933 novel, *Lost Horizon*, which tells of a utopian lamasery tucked in the furthest reaches of the Himalayas, in a place of everlasting tranquility and plenty called Shangri-La. Drawing on this discursive tension between poverty and beauty, the website of the NGO with which I first went to volunteer organizing health camps in Humla in 2004 offered the following description of "Shangri-La and the Hidden Himalayas" to attract would-be voluntourists, oddly enough as the Maoist People's War ramped up in the district:

The upper Karnali River zone in NW Nepal is one of the poorest in the world... Little wonder that most NGOs gave up when faced with the challenge of even accessing this area, let alone providing support to the people that need it most.

Tourism is one of the biggest industries in Nepal... But the vast majority will never travel beyond the honeypots of the Kathmandu Valley, Annapurna, Pokhara and the Everest Region. Few will take the challenge of traveling in this remote area, but if they would, they could be lucky enough to experience the mythical Shangri-La... believed to be hidden deep in the mountains around Humla, a place of peace, tranquility and happiness, where all the inhabitants are enlightened, and the people live without war or famine.<sup>80</sup>

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<sup>79</sup> The Shangri-La branding has also been successful in bringing NGO-run tourism projects to Humla. Currently underway are plans to finalize a Great Himalayan Trail (GHT), a joint project between Humla-based NGOs and the UN World Tourism Organization that seeks to popularize a trekking route spanning the entire length of Nepal's Himalayas, from its eastern border with India to Humla's Tibetan gateway to Mt. Kailās. During fieldwork in 2010, pilot programs to train teashop owners, porters, and guides, as well as discussion workshops at the DDC level, were underway in Simikot. Posters to advertise the Humla portion of the trail were printed with the following quote from Michael Wood of the BBC: "If there was a real Shangri-La, this place is its living descent." The undeniable conditioning influence of travel writing indulging in the Shangri-La image seems to be at work here (DesChenes 2007: 213; see also Bishop 1989 and Liechty 2005).

<sup>80</sup> Beyond the embellishment used here to recruit volunteers, there is a modicum of truth, in this description, but it needs qualification. Rather than Shangri-La being hidden deep in the mountains of Humla, it would be more accurate to suggest that some who live in the mountains of Humla, at times, held a deep belief in a Shangri-La, as Nancy Levine documents (1988: 259-262). In her study of polyandry among the Nyinba of Humla, she notes that, in 1967, the second most common reason given for emigrating out of a community that placed tremendous importance on heredity and social obligation was a search for a "hidden valley paradise." In 1980, the search for these secret refuges (often referred to as *beyul*) still ranked second, behind 'external marriage' and above 'search for a better life.' The underlying reasons for this utopian search are complex and tied to the cultural dynamics of polyandry amid changing political and economic conditions. She notes the Nyinba belief that, during times of great hardship "such Shangrilas would open their doors to people with the foresight to find them" (sic). For the Nyinba and other groups in the region at the time, a decline in trading profits from the loss of livelihood opportunities in the district created social and economic difficulties that had not been present for generations (see chapter five).

While these actual circumstances of living in Humla can jar cruelly with those in Hilton's novel and other popular representations of the Himalayas, these representations tread a well-worn literary past. Historical narratives of Nepal illustrate the ways in which the country—and, in particular, its remote mountainous regions and inhabitants—have been imagined and represented by early visitors, including colonial administrators and envoys, explorers, and medical missionaries.

Along with the idea of Nepal as a “closed” and mystical Shangri-La followed closely, if paradoxically, representations of sick and poor people similarly shut off from—and, therefore, in desperate need of—modern medical care. It was, perhaps, the accounts written by and about the early medical missionaries that came to heal and ‘do good’ in Nepal that most solidified these representations. For example, in *A Heart for Nepal: The Dr. Helen Huston Story*, Hankins (1992: 37) writes that Nepal has been,

set apart by the fortress mentality and isolationist course its leaders chose. Nepal remained closed to foreigners and foreign influence for more than one hundred years. While the rest of the world moved on, many countries making progress even through colonial influence, the tiny kingdoms that now make up Nepal slept through a Rip Van Winkle time warp. The land stood still and froze into a feudal system in which poverty and disease thrived. Apart from royalty and a privileged elite, the people lived a dim existence, trapped in the Middle Ages.<sup>81</sup>

Here it is necessary to unpack a bit the trope of Nepal as a “closed” land. Scholars of Nepal have often commented on how its rulers adhered to a policy of isolationism set out by King Prithvi in order to protect their power and region. And, indeed, before Nepal became more freely open to the outside world, five times as many foreigners had visited the remote capital of Tibet, Lhasa, than had been to Kathmandu (Liechty 2005: 20). However, as the historian John Whelpton (2005: 235) notes, “Outside influences have always been important in Nepal, even when its policy was avowedly one of self-isolation.” Mark Liechty (1997: 7; see also 2003: 153) draws on Helms’ (1988) ethnographic examination of power, knowledge, and geographic distance to highlight how the Nepali elite employed a policy of “selective exclusion”—as opposed to strict isolationism—as the country entered into regional political, economic, and cultural spheres. Nepal’s rulers strove to balance the threat of invasion by the neighboring East India Company

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<sup>81</sup> See Harper (2003, 2009) and Shah (1993) for critical discussions of the medical missionary past in Nepal. For (auto-)biographical accounts, see Fletcher (1964), Hale (1986, 1989), Hankins (1993), Hawker (1984).

while simultaneously attempting to harness their material, technological, and ideological power—that is, the “power of foreignness.”

This power was also firmly bound up in the perceived ability to heal the sick, and as Liechty (1997: 20) notes, “By the late nineteenth to early twentieth century, doctors, dental surgeons, and even X-ray doctors made up by far the largest category of Europeans invited by the Rana government.”<sup>82</sup> The Austrian Capuchin monk, Father Greuber, had passed through Nepal on his way back from China and, along with other monks who had recently been expelled from Tibet, was allowed to preach and practice allopathic medicine (Dixit 2005: 4). However, after King Prithvi’s final conquest of the valley in 1778, many of the fathers were cast out, as he believed that they would encourage the further arrival of outsiders, particularly the British, bringing true the famous dictum that ‘With the missionaries comes not only medicine but the musket’ (Dixit 2005: 5; Whelpton 2005: 37-8).

Thus, fathers of the order and other missionaries would remain outside the Himalayan Kingdom of Nepal until its official policy changed again in 1951. Yet, as Perry (1989: 17) notes in her *Biographical History of the Church in Nepal*, at least a “century of preparation” was already underway; it was only a matter of timing and being ‘called by god to the closed land.’ In the words of the Dr. Bob Fleming, “We Christians waited two thousand years to get into Nepal” (Fletcher 1964: 17), and after 1951, missionaries streamed into the country. God also spoke to missionaries like Ruth Watson and told her that, “One day she would enter that forbidden land, shut tight to all foreigners” (Hawker 1984: 14). Drs. Bethel and Bob Fleming, two “space age missionaries,” were similarly called upon ‘to work with sick bodies and eager minds’ and ‘to heal and bring hope’ (Fletcher 1965: 16). Together, they

trekked happily together over the high Himalayas and slid down a mountain of mud to bring modern medicine to the fabled valley of Kathmandu, [where] they found nine million people fighting a losing battle with almost every known disease from cholera to worms (*Ibid*, 15).

Other medical missionaries were lined up along the 500-mile stretch of the Indian-Nepal Terai border, establishing key strategic points where they could operate “preaching tours” combined with mobile clinics that combed the area while they waited (Perry 1989: 40-42). We, therefore,

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<sup>82</sup> Popular travel and fictional literature about this period in Nepal often have characters who are physicians invited (often from their colonial position in India) to treat noble or royal figures (e.g., Peissel 1966: 196).

might trace some of the earliest short-term medical camps and medical volunteers in Nepal back to this period, before the country officially “opened” its borders.

The rest of this chapter takes a close up look at Nepal’s “modern medical missionaries” (Panosian and Coates 2006), who now come through international NGO-affiliated volunteer programs, global health trips, and other medical student electives. Though medical volunteers do not typically speak of being called by god to Nepal, many often identify their reasons for coming as something similarly nameless, sometimes referring to a sudden awakening, a searching, or an awareness that going to ‘do good’ for people who are sick and poor was simply the ‘right thing to do.’ Below, I examine the social and political effects and afterlives that surround these short-term medical volunteers working in remote Nepal,<sup>83</sup> most of whom I met when they landed in Humla, as word of any arriving *bideshi* doctor spreads quickly. Others were volunteers with whom I worked at NGO-run health camps, and still others I met in Kathmandu after they returned from volunteer programs.

My initial research surrounding this phenomenon examined how medical volunteers and those with whom they interact experienced the ethical dimensions, benefits and limitations of short-term medical work (Citrin 2011). However, a closer analysis reveals the dynamic social lives that surround medical volunteers as they circulate as a healing commodity within plural medical systems and local economies of meaning. As they do so, they shape local ideas and practices surrounding medicine, health, and hope, as well as (re)constitute Humli people’s ideas about their status in a globalizing world. To better understand these social lives and traces of short-term medical volunteer work, it is first important to understand why volunteers come in the first place, a topic to which I now turn.

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<sup>83</sup> I recruited nineteen medical volunteers from eight different countries affiliated with eight different NGOs (Table 2). Volunteers were selected based on the following eligibility criteria: (1) previous or current involvement in a medical volunteer program with a university or NGO that lasted no more than three months in Nepal; and (2) a willingness to participate in the study after being carefully informed of risks, benefits, and rights as a participant. All of the medical volunteers I interviewed during my research were from high-income countries, and most (15 of 19) were between the ages of 20-35. 58% (11 of 19) of the volunteers were female and, with one exception, were Caucasian.



**Figure 4.1** The author (left) interviewing a medical volunteer in Humla district.

NGO	Nationality of MV	Sex	Medical Training	Location of Interview
NGO 1	USA	M	Medical Student	Kathmandu
NGO 2	Sweden	F	None	Kathmandu
NGO 3	Austria	M	Physiotherapist	Humla
	Austria	F	Nurse	Humla
	Austria	F	Medical Doctor	Humla
	Belgium	M	Orthopedic Surgeon	Humla
	Austria	F	Nurse	Humla
NGO 4	England	M	Medical Doctor	Humla
	England	M	Medical Doctor	Humla
	Holland	F	Nurse	Humla
	England	M	Medical Doctor	Humla
	Scotland	M	Medical Doctor	Kathmandu
NGO 5	Germany	F	Medical Student	Kathmandu
	Germany	F	Medical Student	Kathmandu
NGO 6	USA	F	Medical Student	Humla
	USA	F	Medical Student	Humla
	USA	F	Medical Student	Humla
NGO 7	USA	M	Medical Student	Kathmandu
NGO 8	USA	F	Naturopathic Doctor	Humla

**Table 4.1** Participant Medical Volunteers (MVs) by Nationality, Sex, Medical Training, and Location of Interview.

## **“Paul Farmer Made Me Do It”: Motivations for Coming to Volunteer in Nepal**

I met Adrian at the Tribhuvan International airport in Kathmandu. It was early morning, and I was sipping scalding milk tea in a tiny, amazingly robust plastic cup. “I could do with one of those,” Adrian said in an attractive British accent, and he told me of how he came to be in Nepal, and what he hoped to accomplish as a volunteer. “Well,” he started in the hesitating and self-effacing laugh I would come to know quite well over the next few months, “I knew I always wanted to do this, but I can’t believe I’m here.” The day before, I had received a phone call from Kumar, a Nepali friend and experienced travel coordinator for the NGO with which I used to organize health camps. I was on my way back to Humla in 2010 to continue with my dissertation research, and Kumar asked if I wouldn’t mind accompanying a British medical doctor who was also headed up there to volunteer for three months. I gladly agreed, eager to have a companion on the two-day journey, especially one that might serve as a key informant. Because of my own experiences as a medical volunteer, I wondered what had led him—and other medical volunteers—to Nepal.

Volunteers expressed a variety of reasons for coming to Nepal, such as seeing the world, trying something new, learning about different cultures and health care challenges in the developing world, gaining international experience for school and careers, or taking a break from them. Commonly cited task-oriented goals included improving local infrastructure, doing health education, running medical camps, going on medical treks, conducting needs assessments, creating medicine supply chains, training health care workers, and honing clinical skills. Some participants had clearly thought about their destination and goals, while others reported being more “open-minded” about the opportunity. Several volunteers were drawn to the region for travel-related reasons, or had been to Nepal previously on a trek or expedition, and were drawn back by its beauty. A Swedish tourist-turned medical volunteer recounted her reasons for coming like this: “Nepal is at the center of peace, it’s so beautiful. I came to do yoga, and just felt like I had to stay here and be a part of that. I don’t know why...I’m supposed to be here, ya know?”

However, within these broader discussions every volunteer I interviewed expressed a desire to ‘help,’ ‘do good,’ or ‘give back.’ Many volunteers linked this reason, often quite passionately, to an awareness of privilege in education, socioeconomic status, and overall

opportunities. In ways not dissimilar to those I personally describe above, volunteers became reflexive about their own western, more comfortable lives. As Adrian explained to me,

Once you begin to learn how sick the world is—and I mean that in more than one way—it’s clear that helping is our responsibility. I’m beyond words looking around here at the poverty...I’m very lucky and privileged...I don’t have to do agriculture...I’m managing to go to medical school and get this paper that says I’m apparently a useful human being, in my own country anyway. But here, if you get sick your destined to stay sick, or die because of so few options...Short answer is, it just seemed like the right thing to do.

An American doctor of Naturopathy told me that she had no idea what to expect coming out to volunteer in Humla: “I just knew I wanted to come to the mountains, and while up here try and learn about the culture and do some humanitarian work, to do something good,” she said. “When we have so much at home...oh, it’s just...you don’t even know what to do with it all. And here I have skills that I can use to treat people in need, how can I not use them?” Medical volunteers often discussed their reasons for coming in terms of this obligation to address some universal right to health care denied to populations in great need. “We take health care as granted,” a volunteer Austrian nurse told me. “It’s free back home...and it’s a right these people would kill for.” “As doctors of the world, we have a global responsibility,” a Belgian surgeon told me when I interviewed him at an orthopedic surgery camp in Humla.

It is, then, perhaps not surprising that Dr. Paul Farmer was mentioned, unsolicited, by nine of the nineteen medical volunteers during discussions about their reasons for volunteering. Universities and medical schools around the world are increasingly requiring students to read Tracy Kidder’s (2003) book *Mountains Beyond Mountains*, a biographical account of the Harvard trained medical anthropologist and physician who has become one of the most prominent figures in global health as a result of his writing and advocacy around health care as a human right.<sup>84</sup> One evening, I found Bernard, an American medical student, reading Farmer’s book *Pathologies of Power*, and he summed up nicely the sentiment of many volunteers:

I’m not making myself out to be some sort of wonderful, completely ego-detached human being, but I didn’t come here for myself. That wasn’t a priority. I read

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<sup>84</sup> In 2006 at the University of Washington, *Mountains Beyond Mountains* was the inaugural “common book” for all incoming first year undergraduates. As such, Dr. Farmer, the concept of “structural violence,” and the work of Partners in Health were discussed in classrooms throughout the campus. In November, Farmer came to give a talk about his global health work, which culminated in the exhortation for students to “hit the villages!”

[*Mountains Beyond Mountains*] like everyone and it inspired me...What he says about a privilege for the poor, it is what we should all be doing...And, I know I can't be Paul Farmer, that's not the goal here... It sounds so silly, but why am I here? Well, yeah, Paul Farmer made me do it [laughing].

It is notable, dare I even say hopeful, that those who find themselves abroad on medical volunteer and global health trips mention Dr. Farmer so frequently. Yet if one reads a book *about* Paul Farmer, like *Mountains Beyond Mountains*, the take home message is rather different than if one reads a book written *by* Paul Farmer, as Bernard also pointed out to me. In the case of the former, it may seem like the right path is to strive to be someone like Paul Farmer 'who would cure the world.' "Well, OK everybody wants to be him a little bit," Bernard told me quite candidly. However, in his writings, Farmer situates his own arrival in these destinations in social and historical contexts. He also goes to great length to suggest that, without knowing the history and language(s) of a place, as well as understanding and seeking to analyze the larger socio-cultural and political economic factors that surround and unevenly constrain opportunities for a healthy and hopeful live—what Farmer refers to as “structural violence”—we may not be able to do the good we intend to do. Farmer writes, “It is doubtful that the destitute and sick have much to learn from us...but there is little doubt that, as their students, we can learn to better convey the complexity and historicity of their messages” (2003: 242). This humility is admirable, and it might very well be contagious.

Yet some scholars, doctors, and activists argue that Farmer does not go far enough in analyzing the effects and afterlives of his own 'coming and going,' such as how his end-runs around 'corrupt and inefficient governments' does little to strengthen their national health systems. Others have critiqued him for not doing enough to actually challenge the underlying political and economic structures that confine life chances in his pursuit of a radical medicine. They suggest that the position of political neutrality and impartiality often espoused by Farmer in his discussions of structural violence may risk conflating full on domination with other forms of social disparity, diffusing the significance and responsibilities associated with both (Wacquant 2004: 322; see also Bourgois *et al.* 2004; and Dubal 2012). To speak of being a 'partner to the poor' in their struggles against a continuum of violences without differentiating between these violences may obscure how the privileged who come to help remain complicit in, and even benefit from, these systems of oppression. This may lead us to champion the projects of

privileged groups of ‘doctors, activists, and donors that help the poor out of moral sentiment, [but who] refuse or erase their own class responsibility’ (Dubal 2012), and in this way collude to mitigate but not challenge the larger global forces that prop up policies and practices that entrench inequalities. Marx called this kind of humanitarianism a form of “conservative, or bourgeois, socialism” that seeks to dull the cries of people without redressing the causes of their grievances (Marx and Engels 2012 [1948]: 70).

These critiques of Paul Farmer, notwithstanding, he—or what he has come to represent—has become an animating force that (intentionally or otherwise) peddles the experience of a particular kind of global health narrative (cf. Brada 2011; Wendland 2012), as Bernard and Adrian make evident. His aura now serves as a catalyst for the flow of short-term medical volunteers in the form of clinicians and students who are in search of doing good; who head out in search of curing their own worlds living in the mountains beyond mountains, and the Hidden Himalayas fit perfectly in this spot. Undoubtedly, the growth of medical voluntourism will have mixed effects on the volunteers and the host institutions and communities. The danger, though, of the “Paul Farmerization” of global health trips may lie in how the continued, intermittent presence of privileged practitioners from the global north may help to merge the imagery of Western biomedicine with wellbeing while effacing the complex nexus that links health care with health outcomes. This is another potential form of conflation, and just one kind of social (after)life associated with short-term medical work, which I now explore in greater detail.

### **Tracing the Social and Political Lives of Short-Term Medical Volunteers in Humla**

Discussions and observations with medical volunteers and the Humlis with whom they interact reveal the active social and political lives that surround this model of short-term care. The idea of tracing social lives entails looking at the uses, meanings, and consequences of this fleeting form of medical work as it is simultaneously ascribed value and viewed with ambiguity in specific settings by a range of actors. How are the social lives of short-term medical volunteers shaped by social, political, and medical relations, and how in turn do they shape these relations in the places they land? How, and in what ways, might the experiences, traces, and afterlives of these encounters persist even after medical volunteers have come and gone? In the following section, I

seek to answer these questions. I have divided it into five thematic areas, which I discuss in turn: (i) The impacts of medical volunteers on local health care delivery; (ii) medical harm and medical exception; (iii) foreignness and foreign medicines as they relate to the medicalization of unmet needs; (iv) medical volunteers as markers and makers of inequality; and (v) the medical volunteer experience as social and professional capital.

### *The Impacts of Medical Volunteers on Local Health Care Delivery*

Common themes that emerged during interviews with medical volunteers and the Nepal health care workers with whom they interacted was the potential for short-term medical volunteer work to be “one-way” or non-reciprocal in terms of benefits, or to duplicate, fragment, be burdensome or disruptive toward already existing local health care efforts. While the effects and experiences of volunteer work were typically discussed in an immediate sense, set in context these interactions clearly reveal the potential traces of this kind of work, which are significant in the larger discussions of the social and political (after)lives of ephemeral care.

In Humla, it is common for several medical volunteer programs to overlap in project and target areas, resources, and activities. The frustrations and fragmentations of health care efforts as a result of their presence were quickly apparent to medical volunteers, who expressed concerns that they were “undermining” belief in local health care workers (as discussed below), “getting in the way,” “creating disarray,” “introducing confusion by making roles unclear,” “pissing people off,” or “stirring the pot” simply by being there. Harrison, a British medical doctor, recalls his first day volunteering:

“I got to the hospital and it was like, am I doing this, are you? Are you my translator? What’s going on?” An Austrian nurse also commented, “I can tell I upset [a government health worker] when I re-bandaged the old women’s arm after he had just done it. That would piss me off!”

In a rare instance of directly addressing the afterlife of this kind of short-term care, one doctor discussed what he imagined his Nepali counterpart was thinking during his first day of volunteer work in the Simikot district hospital: “There was a huge cultural gap there today...and he looked today at me, like, ‘What’s this crazy Western doctor telling me now. I know my job, what does he know? And to an extent, I better respect that because he will stay here and I will go home.’”

Volunteers were often surprised at the number of NGOs that were simultaneously, but separately, running medical volunteer programs in the district. A British medical doctor described his experience volunteering in a sub-health post where, in addition to the government health care worker posted there, he was surprised to encounter another foreign medical volunteer—an EMT with training as a doula—affiliated with a separate NGO also working:

I could tell that there weren't a lot of good feelings toward us and [the NGO]...The next day when we worked, they split us up into two OPDs [Out Patient Department], and we separately began seeing patients. But, shortly after the Nepali lead of [the other NGO] said, 'This is not okay. You can't use our health post for seeing patients. We already have a doctor here who's with our NGO, and we don't want you interfering with that.' There was a lot of tension between [the two NGOs]...and it just felt horrible, and really odd, to be a part of that.

Nepali health care workers regularly described a general lack of coordination between these medical volunteers who, in his opinion, have been unable to improve the health care system. Bijay, one of the veteran Health Assistants at the government hospital said to me, "Now, let's take a look. So many NGOs in this district...so many foreigners come. But where is the effect?" Another government health care worker expressed a similar sentiment about the letdown of so many "big doctors" from foreign countries using a Nepali proverb: *Hāti āyo hāti āyo phussā*, which translates literally as "Elephants come, elephants come, but nothing."

In several instances, Nepali health care workers discussed displeasure with the evaluative role that medical volunteers were given, or simply assumed, during their brief stays. Volunteers often submitted reports on their experiences at the end of their stints, which often included commenting on local health care workers, their skills, and schedules. Chamgyal, a long-time Nepali VHW employed with one of the NGOs hosting medical volunteers expressed anger and fear after being admonished by their NGO program director in Kathmandu who had read in a volunteer's report of this health care worker's absenteeism from the government health post. His comments speak directly to how the afterlives of short-term medical volunteer work impact local livelihoods:

We are also busy with other work...I do not make enough to support my family working [at the health post]. It is true I closed the clinic...I went with my wife to graze the yaks and horses in the high pastures...Who are these foreigners to give

[reports] on what is happening here. What do they know?...What will happen to my job now? Let's see. What to do?

Several medical volunteers mentioned concerns about their presence being a burden on already-sparse local resources. Many felt as though they were using up too much of the local health care workers' time, or displacing them from their own facilities. "They wanted me to work in a hospital as a junior member of staff, which could have easily been taking a job from a local person, which I had problems with," a Scottish medical doctor said. A Nepali Health Assistant working in Humla's district hospital stated candidly, "We spend too much time taking care of [the medical volunteers] and not enough time taking care of the patients." Adrian also came back one evening to the room we were sharing after he and the local health care workers he was training had been "kicked out" of the hospital when other *bideshi* volunteers from a NGO based in eastern Nepal helicoptered in "unannounced" to run a cataract camp. "The irony of being kicked out by other foreigners," he said, "is not lost on me."

The presence of *bideshi* medical volunteer influences also shapes how local health care workers are thought of within their own communities, and how health care workers think of, or reimagine, themselves. This was made clear to me by Sangeeta, an auxiliary nurse midwife I met when I first visited Humla in 2004. "We are the lower staff," she told me during our interview, describing her days working with medical volunteers over the thirteen years she's been employed at the Simikot district hospital. "They did study at big university in UK or that place in rich countries...We do not know as much as they. This is not a surprising thing, and the people here also know this." Even though medical volunteers tried to "work through" their Nepali counterparts, often local health care workers were left with the impression that the medicine they were practicing was inferior, and that "real medicine" was what was practiced in the home countries of these medical volunteers (Wendland 2010: 135). I discuss how medical volunteers shape other local perceptions of 'life elsewhere' below.

Volunteers were also troubled upon discovering NGOs sometimes paid local health care workers for participating in medical volunteer programs, bringing them away from their posts to assist with medical camps, training programs, translation, or guide work for volunteers. One Nepali government health care worker told me the story of a medical volunteer who decided to run a medical camp on their own, without registering with the appropriate governmental offices and councils, of which there are several in Nepal. In order to do so, she hired the local doctor and

health care workers for the day and had them walk several hours to the village where she was volunteering:

Last year [she] came to Humla and she got the idea to hire doctors and run almost like a private camp...And, she said she was using more creativity and getting away from the politics of Nepali health care system. But the job of the doctors and government health care workers are to stay at the hospital to help the people who show up. If she takes them away for her own benefit (*phāida*) then the people will not have benefit.

Aware that being paid to participate had become the norm, medical volunteers articulated concerns about their unintentional complicity in creating disincentives, or fostering corruption and dependency on the intermittent medical care provided by NGOs and short-term medical volunteers. Many volunteers echoed the concern that, in the long run, short-term medical work might be doing “more harm than good.”

Conversely, participants expressed the belief that medical volunteers were, even in the short-term, “better than nothing,” a truism that requires serious scrutiny, and one which I take up below in this chapter and throughout the dissertation. Indeed, discussions and observations revealed some of the more positive impacts of short-term medical volunteer work, such as volunteers working on the construction of new health care facilities or improvements to existing infrastructure. Volunteers often compiled useful health care data, conducted health care worker trainings and evaluations, analyzed health care facility utilization information, and collected morbidity and mortality data. This information was compiled and provided to participating organizations and district level offices.

The encouragement and support given to boost morale of local health care workers, and the concerted efforts undertaken to train them by medical volunteers were also highlighted during interviews. Participant observation confirmed these serious efforts. Both government and NGO-affiliated Nepali health care workers described medical volunteers as patient, thorough in their explanations, and more committed to improving educational outcomes during training sessions. Unlike trainers at the government level—who see trips to remote areas as an inconvenience and, therefore, rarely make them—volunteers came specifically to do this challenging work. One Austrian nurse reflected aloud: “I think they appreciate that we are here and we are taking them seriously, because there is nobody telling them ‘good job you’ve done’...And, working under

these conditions for eleven, in some cases fifteen years, it's just amazing!" A VHW employed by a NGO expressed a similar sentiment:

We have been working here for thirteen years and until now we've never worked with such great volunteers who have been so interested to teach us. And, if we forget anything, we can look at the [teaching] materials they made for us...If we could study with people like this, we too could become doctors.

Nepali health care workers also emphasized more direct benefits to Nepali people, pointing to the genuine concern, high level of skills, free care, and knowledge that medical volunteers brought to remote areas. Several also mentioned that volunteers bring with them and often leave behind medical technology and services not usually available in the region, such as x-ray machines, generators, and ultrasound equipment. Aware that this was "just a drop in the bucket," the Nepali director of the district hospital stressed how "every little bit helps."

Villagers who sought medical care from the volunteers were the most vocal about the perceived tangible benefits. "*Yasto Thulo doctor lai bhagwān le pathāyieko*" (For us people out here, these big doctors are sent from God), a Nepali woman exclaimed after an examination from a medical volunteer at a health post, where she had received several strips of medication, mostly vitamins and antacid tablets. One evening around midnight, a patient with an obstructed urinary system and high fever called on two medical volunteers, who then fashioned a catheter with pieces collected from several trips to various medical facilities in the district headquarters. To be sure, that foreign medical volunteers were present to assist in this instance is serendipitous, but it was a boon nevertheless. In other instances, the potential for volunteers to do harm become evident.

### ***"Help, Harm, and Everything In-between": Medical Exception and Medical Harm on the Global Health Frontier***

Medical volunteers raised a number of ethical concerns during interviews, some of which involved the potential for their stints to have very public afterlives. Filming or taking photos while engaging in health care related activities was one of these issues identified rather quickly by medical volunteers. They expressed concerns that consent for filming was not sought from them or from the Nepali patients. A British medical doctor expressed his frustrations when, on

his very first day, “[The NGO staff] just started filming me seeing patients, examining pregnant women in the clinic. I asked what they were going to use it for, because this has implications for me, as well. If I’m found to be on the Internet seeing patients outside my specialty, that’s really bad for me as a professional.” At the time, I was shy to bring up the implications that practicing outside one’s specialty might have on the local people, as well.

Working outside of one’s specialty or training—and as a result possibly providing inappropriate care or doing medical harm—was a common theme discussed by volunteers. Adrian described working in the same facility with, but completely separate from, volunteer nurses from another NGO: “These nurses [are] general and internal medicine nurses, and they’re working in the labor ward delivering babies? I don’t really get it.” The Austrian physiotherapist similarly remarked, “They don’t even have physiotherapists in Nepal. I’m down at the hospital treating skin infections, which I don’t know anything [about].”

Medical volunteers often discussed this issue of appropriate specialty, licensure, and registration to practice medicine in Nepal. Many volunteers—particularly students—were not licensed in their home countries, but still practiced medicine in Nepal, either at the behest of an organization or because the situation seemed to ‘make it necessary.’ This ‘state of medical exception’ is something I saw frequently in Humla, and is best captured by one of the medical volunteers interviewed in the research documentary *First Do No Harm*.<sup>85</sup> In the film, Elizabeth Miazga, a second year undergraduate science student at the University of McGill, describes her first day volunteering in a hospital in Kenya:

I was terrified...But the thing is, I was in a room, there were two nurses there and the doctor was gone. Three women went into labor at the same time, so the two nurses delivered the other two women. And there was a woman there who went into labor with nobody there to help her deliver her baby...So, I’m unskilled...So though I’m not the most skilled person in Canada and I’d never, ever be allowed to do that. But here, when the choice is between me and no one, there are different standards because there have to be different standards. I’m not saying it’s right, but it’s better than nothing else.

This idea of “better than nothing” is a rationalization that seems inevitably implicated in instances of medical harm, as I illustrate below.

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<sup>85</sup> The entire video is available at: <http://vimeo.com/22008886>.

Many medical volunteers I interviewed were licensed practitioners at home, but never managed to register with the Nepal Medical Council (NMC), the national regulatory body that oversees all medical institutions and practitioners, including licensed foreign medical personnel participating in health care work. In interviews, volunteers listed reasons why registration was often not completed, such as a need to fill out complicated (and often seen as unnecessary) documents that were incommensurate with credentials in their own countries, absenteeism in the pertinent offices, and “load-shedding” or *bandhas* (business and transportation closures/strikes) in Kathmandu—all of which made completing registration procedures in a timely manner difficult. Of course, the notion of ‘timely’ must be viewed in the context of these short-term stints, lasting only between a few weeks and a few months. According to an Austrian physiotherapist,

We knew about the registration, but there were problems with the changing of the Minister of Health, other workers not showing up, no power, and no printer, as far as I could see...And, the strikes and traffic...I couldn't imagine how complicated it would be to fill in so many different applications and bring in so many papers and certificates that don't even exist in Austria. So, no, we didn't manage [to register].

Volunteers who were licensed at home but did not register in Nepal discussed the strategies they employed to avoid practicing medicine directly, which they often couched in the language of harm reduction, or, at the very least, in an effort to minimize the chance that they could be seen as doing any medical harm. Medical volunteers said they just “consulted” with the local health care workers seeing patients, but “didn’t personally give out any pills,” or “worked through” their Nepali counterparts, “directing” them “to make sure they didn’t give out the wrong thing,” but also making sure to ‘make it look, or let them feel, like they were in charge.’ This also contributed to an ambiguous sense of the roles and responsibilities assumed by medical volunteers, particularly among local Nepali health care workers.

Another British medical doctor, who did not intend to perform surgeries while volunteering in remote Nepal precisely because of concerns of medical harm, expressed surprise in recounting his experience registering with the Nepal Medical Council: “They took issue with [not wanting to practice], and said I should give [surgery] a go ahead if an emergency demanded. Once registered, there isn’t much limit to what you can do out here in the mountains, except from one's own ethical standpoint and common sense.” It is difficult to know what is “common

sensical” about the practice of medicine in a place where language, culture, and conceptualizations of sickness and wellbeing are so completely different from one’s own. It seems appropriate for us to ask here, in what ways have Nepal and Nepalis been historically “sensed” by foreign visitors; such as by missionaries envisioning themselves off to heal forgotten inhabitants of Shangri-La. We must remember here how the extended social lives of health-related representations endure in the brochures and advertisements that attract, travel with, and ultimately shape the perceptions and practices of Nepal’s modern medical missionaries.

For Maritta, an Austrian medical doctor I met in 2009, a situation appeared during her volunteer stint at the district hospital that seemed to transcend the matter of registration. Maritta was in Nepal, and Humla, for her first time, and she was “scared as shit” upon arriving her first day. She had mentioned to me in our interview that she felt “competent as general doctor at home, where [she] was familiar with the way people lived.” After her third day volunteering at the Simikot district hospital, the local District Health Officer (DHO) had flown out of the district for a seminar, leaving only her and a few Health Assistants (HAs) behind at the hospital. A few days later, a young girl who had fallen from her family’s roof was brought in with a gangrenous arm to just below the elbow. Maritta was licensed at home, but she had not managed to register with the Nepal Medical Council. She recounted the events resolutely:

Of course I cut her arm off. What was I going to do, not amputate?...I’m not trained as a surgeon, and I’m not supposed to do [surgery] here, but this girl could have died...Her family wasn’t going to do anything, they’re so poor. What can they do? I didn’t even think about it, it was clear that this was the right thing to do.

Several days after Maritta completed her two-month stay in Humla, I interviewed Ram, the Nepali government health worker who assisted her at the time of the amputation. Ram articulated his own concerns, demonstrating how local liabilities and the afterlives of medical volunteer work can extend beyond official or legal repercussions. “If something went bad with the girl’s situation,” he said, “it is not any committee who we need to fear. It is this girl’s family and community. They will come shouting to the district hospital, asking for money or our heads, not our jobs.” Ram’s words stands to remind us how, even in the face of seemingly clear ethical decisions from the perspective of medicine, the potential afterlives of short-term care may not be immediately clear to those who do not stay to see the multiple ways they unfold.

Another example of how medical harm and ethics intersect to shape particular experiences and afterlives of short-term care comes from a general health camp I attended in Humla in 2006, when a woman presented with worms so large that they had perforated her stomach. After her initial examination, she was declared an “emergency case” and immediately prepped for surgery. A team of foreign medical volunteers discussed whether or not to operate on her, but in the end they decided to go ahead. After all, they had come to ‘do good.’ The woman went into septic shock. Plans were immediately made to fly her down to the nearest capable hospital the next morning, after the money required for her care was quickly offered up by the volunteer doctors. Many at the camp celebrated this altruistic gesture. However, for at least one camp attendee I spoke with after the event, this was a visible sign of inequality, of the ‘source-force’ that the majority of Nepal villagers lacked:

We heard one woman was flown to Nepalganj [the nearest city] by [an NGO]...that is, they covered the expenses too. This is good, but it is not equal. For us poor people who have no money for treatment, we expect the health camps to be free. We hope they will be free, but it should not be free for some and not for others. She will get care and after my wife’s operation, where will we go?

The production of different kinds of inequalities is another direct, if not inevitable, outcome of short-term medical engagements like these, a topic I discuss further below.

The critically ill woman’s family sobbed as her stretcher folded up into the rear of the plane, but not before one of the volunteer doctors could snap a photo with the woman in front of its Yeti footprint airlines logo. The anesthesiologist who attended to this woman returned home and published an article describing the experience (Roberts 2007: 5):

Finer issues of clinical governance recede quickly in the rarefied air and a consideration of risk/benefit ratio overrides all others...Anaesthetizing a critically ill patient with septic shock provided several firsts for the region: the first use of inotropes; dopamine via a drip in drops per minute. Post-operatively the relatives outside thought this was the elixir of life and proceeded to open it up fully at every opportunity, providing an interesting set of blood pressure readings on the charts. On enquiring if any blood could be made available, 40 minutes later I was both surprised and delighted to receive a bag of type-specific blood, a first for Humla. This was not really the time or the place to question its origin so after checking its compatibility with the patient, she became the first recipient in the region of a blood transfusion. The laparotomy revealed a perforation of her small bowel from ascaris worm infestation, which the surgeon had to pull from the perforation: not my most pleasant

viewing experience in an operating theatre! ... We left fatigued, dirty, yet euphoric in the knowledge we had at the least contributed to the philosophy of improving healthcare to the population of Humla region, Nepal. And memories to last a lifetime! Namaste!

This description exemplifies the state of medical exception, where medical decisions are reconstituted because of the ‘time and place’ in which they are perceived and acted upon. This description also fits the typical “aid cowboy” that James Pfeiffer (2003: 729) describes: “non-ideological specialists and professionals not particularly interested in...political history, culture, the context of international aid, or philosophical concerns with ‘development.’” These are cowboys roaming what Brada (2011) calls the “global health frontier,” involved in the flexible and borderless reach of biomedical practice in temporal situations that appear to create their own principles and demands (Tsing 2005: 32, in Brada 2011: 303).

In conceiving of contemporary “global health care chains,” and as we speak of the “brain drain” that draws the educated strata of poorer nations away from public sectors and often to other countries (e.g., Hagopian *et al.* 2004), we must also think on the ethics of medical voluntourists who participate in short-term health care in resource-limited settings with differing levels of accountability. Not checking the origin of the blood—even for a moment to see if any information was available from the ill woman’s family waiting outside—is negligent at best in a part of the world where conflict, business, and labor migration cause increased travel over the Indian and Tibetan borders, and where the trafficking of women and girls remains a shamefully gendered evil on the rise alongside HIV/AIDS.

As a result of the surgery—though clearly not the ultimate cause—this woman was flown down to a hospital to die far from her family, a terrible tragedy in Nepal. One Nepali doctor who attended the health camp suggested that the woman’s spirit was now likely to wander, maybe in the hospital where she died, potentially never finding peace. For this woman’s family, the traces and afterlives of this ephemeral medical care now combine with localized cosmologies of ancestral spirits who, without being shown the appropriate rites of death and propitiation, in turn, may become a potential source of ill or misfortune to someone else in the future.

It is worth considering whether this kind of medical intervention for someone who, as another volunteer doctor at the camp noted, “Would have died under the best conditions in the UK,” is indeed better than nothing? What kind of contribution is this to the “philosophy of

improving health care”? Perhaps a closer look at this phrase is needed, as Carolyn Nordstrom (2009: 73) suggests: “Who is it that cares? What exactly do they care about?” I agree here with Wall et al. (2006: 560) who argue that, in these instances, “the tendency to put one’s surgical ego first and the best interests of the patient second must be resisted at all costs.” However, in many ways the socialization of medical education—at least in the U.S.—is embodied in “the laying on of hands,” as Howard Becker (1993 [1961]) and Mary Jo DelVecchio Good and Byron Good (1989: 304) pointed out long ago. Here, perhaps, the sense of responsibility to do something medical is captured in “the idea that you weren’t fully operating as a doctor unless what you did could, if done wrong, kill people” (Becker 1993 [1961]). In the newly constituted global health frontier, the spatial, moral, and temporal dimensions of calculating medical harm and medical exception seem increasingly vague.

When I returned to Humla the following year, I had a chance to ask Sangeeta, one of the veteran government health workers, how the communities responded to the loss of this woman, along with two other camp attendees in the district who had died of post-operative complications in the weeks following the camp. Her comments speak directly to both the immediate experience and traces of short-term medical intervention by foreigners, who are seen in this instance in a particularly ambiguous light. Another afterlife is seen in the extra time and care required by Sangeeta to “follow up” on the ephemeral care offered by medical volunteers at this health camp:

The view of the people is that at least a foreign doctor should stay...How can they leave? This kind of situation should not come. For example, I have done the dressing [for] a foreign doctor with my own hands for three or four months after she did a uterus operation at the camp. If [an NGO] conducts health camps it should manage at least one person to stay who knows about gynecology...or those who know about other parts of the body...The people come from such a far distance for foreign doctors to completely cure the disease and feel secure, not put their life on death. If people have to go to the nearest city for the treatment of infection, buy medicines themselves, or lose their life, what is the meaning of a health camp?

I discuss other “health *complications*” in the next chapter, but it is worth pausing to consider these comments. Bezruchka (2000: 77) has written on medical tourism as medical harm to the third world, cautioning those who wish to volunteer and do good to consider what they know or don’t know about health and its determinants at home before heading overseas. “Medical harm” is a difficult concept to pin down, but, let Ivan Illich’s (1975: 17) evocation of iatrogenesis serve

as an entry point: afflictions that would not have come about if sound and professionally recommended medical treatment had not been applied.<sup>86</sup> In short, medical harm could be called the paradoxical damage caused by medical practitioners trying to cure sickness (Ibid, 17). To limit medical harm, Bezruchka (2003: 33) proposes, the best motto is “Don’t just do something, stand there’ — unless it is obvious that doing something will help.” This point runs counter to what is often proposed as the core tenant of international volunteer work. For example, the organization Meaningful Volunteer has espoused three steps in thinking about what constitutes “meaningful” work, the first of which says, “Do something! Anything!”

As the comments of medical volunteers make clear, the binaries of right and wrong, or help and harm, break down in situations where basic needs are not met. Nevertheless, in these contexts, the afterlives of short-term medical work are not readily discernible, and those who practice it will not be around to trace them. The ambiguity that surrounds the presence, practices, and afterlives of short-term medical volunteers was articulately evoked by Adrian, who said to me one evening as we sat on a flat roof beneath a crested Himalayan moon, gesturing to our surroundings, “Here, it seems hard to make sense of help, harm and everything in between.” The “here” in his comments also signifies the world that he and I both come from as distinct from the world where we sat on that roof; a world where the potential to do harm is recalibrated in seemingly extra-ordinary circumstances by medical volunteers who are sought out because of local perceptions surrounding their inherent ability to cure, and the presumed power of the medicines they brought.

### ***The Power of Foreignness, Foreign Medicines, and the Medicalization of Unmet Needs***

One of the most commonly discussed themes in discussions with medical volunteers was the heavy dispensing of medication in settings of poverty and scarcity, even when this was not the intention of volunteers. Volunteers described major limitations in their ability to address the underlying causes of disease or suffering, while also acknowledging that they had come to Humla to work with what was available to provide medical care. However, without diagnostic equipment typically used at home or the ability to communicate and take patient histories, and in

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<sup>86</sup> “In a more general and more widely accepted sense, clinical iatrogenic disease comprises all clinical conditions for which remedies, physicians, or hospitals are the pathogens or ‘sickening agents’” (Illich 1975: 18).

light of the demand for medicine and few options for referral, volunteers often found themselves giving out short courses of vitamins, cough syrups, eye drops, creams, pain medications, and antibiotics. This raised not only worries about side effects, antibiotic drug resistance, and inappropriate regimens, but also serious concerns about the medicalization of poverty and basic needs that were not being met in Humla.

This is a thread that weaves through my larger argument about the potential long-term consequences of short-term models of medical care. Yet, here the broader context in which volunteers find themselves participating in these practices of medicalization are bound up in local perceptions and comparisons of their countries of origin. As one American student mused aloud, “What’s the point of having a number of volunteer doctors coming out here and giving out pills a week at a time. It’s just wrong. It’s dangerous. Is it because we are Americans?” Similarly, the American doctor of Naturopathy told me, “It’s so frustrating to come here and hand out a week’s worth of medicine based on some symptoms, and no follow up...It just fosters this mentality of ‘give me some medicine so I get better.’” A German medical student said that if she had known “that by primary health care they meant simply giving out medicine, I would have reconsidered this trip.” Other volunteers expressed similar frustrations in the face of simply handing out medicines without being able to address the illness-causing conditions in which people lived:

People were defecating in their own water supply, animals were being killed in it, and people were dying from diarrhea and pneumonia, from very basic health problems, which were totally preventable. And I wasn’t in a position to do anything about it but give them antibiotics and hope they eat them all. (British medical doctor)

How do I tell people that their chronic pain comes from a life of chronic work, which they can’t stop because their ability to eat depends on it? I just feel like I’m doing Band-Aid medicine. (American medical student)

The nurses working with me would say, ‘Give them medicine and send them off, or give them some paracetamol, that’s what they’re expecting. Don’t for one second say what the reality of the situation is to them. In fact, they wouldn’t translate it for me...I would try to say, ‘Well, it’s because of the way you work,’ and they would say, ‘You can’t tell them that.’ (Scottish medical doctor)

Adrian expressed a similar sentiment to me after a long day of seeing Nepali villagers in a remote sub-health post:

I can't help but wonder if I'm treating hunger pains here. I don't know how much they've eaten today, or yesterday...What will these pills do?...But, I'm a frontline health worker, there's little I can do to break the poverty cycle here...I'm trying to leave even a little bit of lasting benefit, but I'm starting to feel like I may not be contributing to anything at all. You wonder...well, no, it seems pretty clear that we can do better than this, than me [pointing to himself].

Several Nepali health care workers and NGO staff echoed concerns about simply handing out pills—concerns they know very well—but that this was “the thinking/expectation of the people” (*jantā ko sochāi*). Ram, the government health worker who assisted Maritta in her surgery, noted how “*Bideshi* medical volunteers are in a difficult position because the people will not leave the clinic without medication. And, it is harder for foreign doctors since the people have more belief (*biswās*) in them.” One Nepali villager who was seen by a *bideshi* volunteer expressed disappointment after his visit when he did not receive medications: “The doctor said I wasn't sick, and didn't give me any pills. He gave me advice...why did I come here?”

Nepali health care workers also pointed out that the greater trust placed in medical volunteers, as well as the aura of efficacy that surrounded medications given by them, stemmed from the fact that they came from *bidesh*, a foreign country. Particularly in remote clinics, when the news of visiting foreign doctors spread, health care facilities experienced higher patient volume. Sitar, a Nepali NGO village health worker (VHW) who used to work in a health post that was constantly staffed by rotating teams of medical volunteers before Maoists ransacked it in 2002, described to me this common perception that surrounded the presence of foreign doctors in Nepal:

There were more patients in the clinic than in the district hospital. It was such a thing, the lines out the door...They walked from 2 to 3 days and came to that clinic instead of coming here to the [government hospital] because they believed that it has better medicine...*bideshi* doctors, *bideshi* medicines, better equipment...But really we didn't have much.

I observed this in several instances. During one such interaction, I watched as a Nepali and *bideshi* doctor sat side by side at a table to take the history of a patient, exchanging turns in listening to her chest, taking her pulse, looking in her eyes, ears, nose and throat. At the end of the examination the Nepali doctor gave the same medicine from the same package to different

attendees. I saw one attendee receive medicine from a Nepali doctor only to then—after examining them carefully with his fingers—showed them to the foreign volunteer doctor also sitting at the table, as if to ask him if he had received the right medication, and the correct amount. The medical volunteer signaled with nodding head and a thumbs up that this was in fact the correct regimen. The intrinsic ability for the foreign doctor to heal is seen here again, even through means of consenting.

I also saw this when I traveled and lived with Adrian and Harrison, who were often stopped on trails and asked for medicines, and woken up early in the morning by Humlis who had sometimes walked days to see them after news of their presence traveled by word of mouth, over trails and across hills. In these instances, volunteers felt compelled to provide medicines. As Adrian commented one evening after doling out vitamins to a group of women who had walked an entire day and knocked on our door after 10:00 in the evening, each complaining of headaches and stomach pains, “Telling them they weren’t sick and didn’t need medicine just didn’t seem right.”

Receiving medication when presenting at any health facility was indeed the norm, and greater trust was indeed placed in medicine given by *bideshi* volunteers, even if the medication was sourced from government stocks. As Harrison, a British physician expressed to me emphatically, “Even if I turn around, open the cupboard, and take out medicine from the health post they always go to, it’s like, just because it comes from my hand, they think it’s better.” Further participant observation and the comments of many medical volunteers and Nepali villagers affirmed this notion, suggesting that *bideshi* medicine is believed to be more powerful, quick acting, and more effective in providing relief. One British medical doctor expressed frustration when this became apparent to him:

I wish I could have told the communities the fact that there is a foreign doctor here doesn’t matter. The health workers do just as good a job...And, they take medicine from our hands and inspect it like it’s magic.

The inspection of medicines by Humlis is done in the context of plural understandings of their properties, something I discuss in greater detail in the next chapter. However, as Ian Harper (2003) points out, magic has always been an important part aspect of medicine and its efficacy:

“After all,” he says, “What else is placebo; that so little understood, and often ignored effect of medical practice?”



**Figure 4.2** At a health post outside Simikot, a parent nudges her child closer so that a volunteer nurse can give her cough suspension.

I have also experienced the magical “placebo effect of presence” during clinical visits in Humla. Being around health posts, hospitals, and asking questions about health, sickness, and medicine during interviews, I am quite regularly presumed to be a doctor. Still, even away from these medical settings, I have been asked countless times for medicines, or to examine someone or treat their child, purely—it so often seems—on the basis of my color.<sup>87</sup> In other instances, government health workers and Nepali doctors have asked my opinion during a consultation, even as they know I am not a clinician of any kind or trained in pharmacology. Thus, perhaps the idea of magic in the context of medicines sought out from medical volunteers is supported by

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<sup>87</sup> One result of this has been a growing awareness of my position as a white male researcher from a rich country, with unearned accumulated privilege, situated prominently within broader systems of privilege and oppression (Heldke 2003: xxvii). As I conduct research, I am continuously reminded of this. As Farmer (2003: 224) fittingly writes: “That we can study, rather than endure, these abuses is a reminder that we too are implicated in and benefit from the increasingly global structures that determine, to an important extent, the nature and distribution of assaults on dignity.”

local perceptions of global hierarchies and possibilities—social, educational, economic, and techno-scientific. This belief becomes invested symbolically in the white skin of those who come from countries where these possibilities are presumed to be greater (Harper 2003). This notion was elicited clearly by Namgyal, a young Buddhist monk who spoke about greater faith in *bideshi* medicine by citing his Rinpoche, who had given a lecture on Western medicine at their monastery: “Your medicine,” he told me “is filled with knowledge and money. This is why your children are so healthy.”

As Harper (2007: 2) notes, “the capacity for biomedical services to cure certain conditions has come to be seen as being an intrinsic property of the foreign doctor and their capacity to heal.” This is a nonmedical view, he suggests, dependent on historical and geopolitical relations and vast material inequalities that exist between Nepal and its Euro-American elsewhere, encapsulated here in the idea and imagery of the pill, and the place in where it is made. The high demand for medicines, then, is bound up in the “power of foreignness”—to return to Liechty’s concept—possessed by the international doctor and the very real and imagined world from where they came. In the next section, I explore how medical volunteers, themselves, become markers of the inequalities between these worlds, shaping local Humli perceptions about real and imagined futures.

### ***Medical Volunteers as Mobile Markers and Makers of Inequalities***

For the most part, volunteers were not blind to the ways in which their presence and practices shaped ideas about mobility, wealth, privilege, places and opportunities, and they regularly discussed the potential unintended consequences that being in Humla might have on their host communities and local institutions. As a Dutch nurse told me,

I think you can do a lot of harm to the people there, to the health workers, to the relationship between health workers and the people. And, you can harm the concept of health and treatment...coming as a volunteer with very different concepts...And it made me think, well, if we come here with a Western concept of being poor, what are we bringing here? Are we reconfiguring their own notions of poverty, like now they know more and more how poor they really are?

The Austrian physiotherapist also commented on how, as medical volunteers, “We don’t just bring medication. It’s also our way of thinking that we’re bringing to them.” The American doctor of Naturopathy also saw her presence in Humla as an inevitable marker of inequality:

This mentality of ‘we are so poor, so disadvantaged, the government and the politicians are so corrupt and ineffective...you guys have to help us because life is miserable here.’ It’s like this feeling that we deserve something from you because you’re rich...And us being here encourages this, so really it’s our fault, because to them we are rich.

Many medical volunteers were aware of being walking embodiments of global inequalities, particularly referencing the expensive clothes, shoes, and other material goods they brought with them, such as solar technologies, GPS and satellite phones and computers. One day, Adrian and I hiked to a teashop at the top of the hill overlooking Simikot, and our boots quickly became the topic of conversation for a group of traders just returning from Taklakot. Many were wearing ripped shoes—the knockoff Chinese Converse that were so common in the region—sockless toes protruding from holes worn in the front. “How much do those shoes cost?” one Thakuri villager asked us directly, fingering the metal eyelets and strong leather stitching of both Adrian’s and my hiking boots. “I’m not sure,” I said sheepishly in Nepali. “Maybe \$150,” I then said, reducing the price by perhaps USD\$100 out of embarrassment I later admitted to Adrian who could not understand the conversation. But even that amount elicited hooting and knee slapping, as each trader proceeded to ask us to bring a pair of shoes like that for them when we came back next time—all aware that we would not, nor could they afford them if we did.

On another day, Bernard—the American medical student who spoke articulately about Paul Farmer—brought up a concern about material inequality that has bothered me since my first trip to Nepal: “My backpack—never mind the contents inside—cost more than these people see in a year. I can’t help be aware of this all the time...They must think we all ride around in airplanes back home.” Indeed, like medical volunteers, the backpacks they (we) bring are markers of inequalities. This also conjures Peggy McIntosh’s conceptualization of white privilege as “an invisible, weightless knapsack of provisions, maps guides, codebooks, passports, visas, compasses and blank check” (1988, as cited in Mathers 2012: 152). As Mathers (2012: 153) notes, westerners traveling in places where poverty is widespread are often assumed to be

wearing “invisible backpacks of privilege,” only they are filled with very real things, such as passports, visas and checkcards.

As Claire Wendland (2010: 135) notes, inevitably medical volunteers take more than photographs and leave more than footprints: “They leave behind images and ideas of what other places and other cultures are like.” They leave impressions of a world most Humlis will never experience, except perhaps through the photos that medical volunteers bring. Yet, for some Humlis, there is a palpable hope that, possibly, medical volunteers might open doors to these other imagined worlds. Requests by community members for assistance in other life areas were also common, such as educational support for children and schools, financial assistance to buy food or animals, or sponsor letters for work or travel opportunities abroad. I, myself, have been asked for all of these things, though most commonly to write letters of sponsorship for friends and research assistants. Feeling particularly indebted<sup>88</sup> to one couple who facilitated my research trips to Humla I wrote the letter. I tried to explain (to them and myself) that I was only a student, with no way of actually fulfilling the financial promise of sponsoring their visit to the U.S. They said that they knew this, and that they would not expect anything from me other than writing the letter. In the end, their applications were denied because the U.S. Embassy suspected that they would not have enough money to support themselves while abroad, even for the thirty-day visa for which they were applying. This realization made one of my friends comment on how expensive it really must be to live in America.

Many medical volunteers and Nepali government workers commented on how far the money volunteers paid to come to Humla would go in the local economies. Excluding international airfare, which volunteers all paid themselves, prices quoted to participate in volunteer programs ranged from (USD) \$400 to \$1000 per month, which included in-country travel, food, lodging, and logistical support. However, where and how this money was spent was not always clear. This often prompted medical volunteers to comment on the ways that money was being spent, and the possible inequalities created by their infusions of cash. In some cases, medical volunteers found out that the money they paid to participate was being misused, siphoned, or that it was going to help “prop up an already smelly system of NGO corruption,” in

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<sup>88</sup> See Catherine Sanders’ (2012) beautiful and thoughtful piece on feelings of indebtedness to those with and among whom we, as anthropologists, conduct research. Accessed, October 24, 2012. Available at: [http://www.huffingtonpost.com/american-anthropological-association/debts-and-indebtedness-in\\_b\\_1973589.html](http://www.huffingtonpost.com/american-anthropological-association/debts-and-indebtedness-in_b_1973589.html)

the words of one Scottish doctor. One German medical student was exceedingly discouraged when she realized her fee covered the cost of a Nepali NGO staff and their partner's flights to a conference in India, as opposed to the homestay family she believed was receiving her money: "That's \$1000 for two people supposed to be focusing on work [in Nepal], not vacation... You know how much you can do for \$1000 here. You could restock the entire health post... And, for [the homestay family], that would feed them for an entire year!" The volunteer eventually called up the Kathmandu-based office to express her concerns (likely to Nepali staff with little involvement or recourse in the situation), and ended up leaving Humla early.

One British physician discovered that the family that was housing and feeding him up in a village during his stay had not been paid the full amount agreed upon:

We've been looked after so well here. The staff they're brilliant... But, when money hasn't been given to the people it should have been given to at the right time, for food we were eating... that's made us feel very uncomfortable, and annoyed because we paid quite a lot of money to come here... Where does it go?... We hope not into a pocket.

Several volunteers mentioned that they were potentially introducing other inequalities when they brought small gifts for their Nepali counterparts or homestay families—something that is commonly recommended to volunteers by their host organization. However, volunteers soon realized that they never had enough. The American doctor of Naturopathy gave out some aprons to the nurses who were helping her in the health post, but "they were unhappy because they wanted full dresses... A few days later, the rest of the staff came asking for clothes and I saw what I had done."

In other cases, Humli people saw medical volunteers explicitly as medical aid commodities (Wendland 2010: 8-9), and volunteers were pulled into the local cultural politics of *āphno mānchhe* and *chakari*. Much like medicines and food aid (discussed in the following chapters)—volunteers become a mobile resource with economic or political significance, circulating through the social channels of currying favor and service. For example, volunteers felt discomfort after realizing that the financial benefits that accompanied their home stays or other volunteer-related duties (translation, guiding, and portering) typically went to relatives or friends of Nepali NGO staff or health care workers. Volunteers often found themselves involved in health care work that would only benefit few within a community, such as having to select

certain people to give the ‘more appropriate’ antibiotics, or having to choose patients for surgeries and turn away many more as a result of limited resources. It was also not uncommon for volunteers to experience pressure from a local health care worker to see a friend or relative after the clinic was closed, or to make a home visit, as we saw with the women who walked a day to see Adrian and were shown to his room after 10:00 in the evening by his homestay family. Volunteers often felt unable to deny such requests, especially when these individuals were acting as their translator, housing, and feeding them; and in many cases, it was all three.

Medical volunteer homestays also shape other local perceptions, particularly around living conditions and food. Humli homestay families often expressed shame when they saw volunteers not using the blankets they were provided because they felt they were dirty, or—as I saw in the case of a volunteer in Simikot—ask for a broom to sweep out their living quarters. As I also encountered (and discuss in chapter six), Humli people routinely apologize to *bideshi* visitors for the foods they serve to them, as they imagine that volunteers are accustomed to eating much different foods, with more variety, or at least used to eating these foods more frequently and in greater quantities. When Humlis are offered food by a host, they will turn it down not as a point of pride, but as a practice borne of a deep-rooted cultural and culinary humility; one would never want to impose in a place where food is scarce. But, in the end, after some extra encouragements on the part of the offerer, the food is gladly accepted.

Volunteers, however, routinely turn down food, even after the offer is made several times. For example, in Buddhist homes, Tibetan tea is served with a heavy heaping of salt and (typically) yak butter—a caloric wonder drink, but one with a taste very different to the sweet, milk tea (*chiyā*) foreigners find more palatable. And, I have seen countless faces of disappointment when volunteers show up for dinner only to find *dāl bhāt* or nettle soup, “again.” Further, for reasons relating to custom and material circumstance, Humli people do not eat a big meal early in the morning, but rather consume two meals with perhaps a snack in the middle of the day. And in Nepal, where the idiom ‘guest is God’ is routinely expressed and put into practice, Humli homestay families feel embarrassed when they found volunteers accustomed to three square meals eating foods they brought from home or Kathmandu in the secrecy of their rooms, or happened upon them buying instant noodles or biscuits at local teashops. Kunjok Lama, a friend of mine from volunteering at health camps and a NGO-employed VHW who has

hosted many medical volunteers over the years, told me that he felt bad for only being able to provide the food that he and his family eat:

I think they are getting so sick of eating nettle soup (*shishnu khāne wākka lāgyo*). We are used to eating nettle soup, we have a habit of eating it and it is enough for us. To us, our food is tasty (*miTho*), you know? In their country what they eat is considered good. [The two volunteers] are very polite, and they tell me that they are okay with eating what we have. What there is, you have to eat it, (*Je chha tahi khānu parchha*) [one of the volunteers] even told this to me. But, you tell me, are they upset with me?

In these ways the dietary preferences and palates of medical volunteers shape what is considered good to eat, what satisfies, what is tasty, and what is ample.

Several medical volunteers also described becoming inadvertently entangled in the local politics of NGOs or political parties, which were themselves often inextricable from real and fictive kinship and configurations of currying favor. One British doctor described how he felt that,

[The NGO] used me, actually. For the first week, I was taken around to the local hospital, and to the district office, and basically they said, ‘We have a Western doctor, can you provide some funding? Can you provide equipment?...So, this was really hard.

Two German medical students described a similar experience volunteering at a health camp outside the Kathmandu valley, where their presence served as political capital for the NGO organizing the camp. Only after they arrived and sat through what they described as a full hour of political speeches did they realize that the NGO was affiliated with the local Nepali Congress party, and their presence was political capital for the NGO and the district political leader who came to open the health camp with much pomp, including a red ribbon cutting:

Well, we couldn’t understand...but the way he spoke, you know, strong talk, sweating a lot and pointing at people and at us, pounding his fist...It sounded more political than about health education...And, then he took us around, introduced us to people...It looked very nice for the party to have foreign doctors coming with them, saying our names, where we were from...But, we’re not even doctors! (German medical student)

## ***Medical Voluntourism as Social and Professional Capital***

*“An orphanage in Nepal, for two months,” I would tell women I’d met in bars. “Sure, there’s a civil war going on. And, yes it might be dangerous. But I can’t think about that,” I would shout over the noise of the bar, trying to appear misty-eyed. “I have to think about the children.”...I needed this volunteering stint to sound as challenging as possible to my friends and family back home.*

~ Connor Grennan, *Little Princes*, 2010

I use this quote here both in the hyperbolic way, I suspect, it is written and as segue into a discussion about the different kinds of capital that accrue to medical volunteers who participate in this model of short-term care. None of them spoke to me in the manner that Connor flippantly writes of his trip to Humla. However, many did speak candidly about the experience as an important part of their futures, both professionally and personally. I, too, am fortunate to have benefited from my short-term medical volunteer experiences, not only in terms of the processes of awakening and radicalization it encouraged, but also in terms of my career. For admission into the Department of Global Health where I completed my Master’s degree in public health, applicants are required to have had a minimum of two years international health experience. For many in the department, the cumulative time spent participating in multiple short-term medical volunteer programs was how this requirement was met. As one British medical doctor told me, “I’m still thinking about this in terms of my career. So, while I planned to do this long ago, it’s the sort of thing I can do at this stage...And, it ends up looking good on your CV, doesn’t it?”

In terms of professional benefits, international medical trips to places like Nepal also provide opportunities for current and aspiring medical practitioners to study and document afflictions that have largely been eradicated in richer countries. In his personal account of volunteering in a historical mission hospital in Nepal, Joe Niemczura describes how he could “barely contain [his] curiosity and eagerness” when he heard a young boy had arrived with whooping cough: “*Whooping Cough. Cool. I want to hear the ‘whoop...’* In the US, you can go for an entire career and never hear the whoop. When you finally do, it is like being in the wild and hearing the call of a rare species of endangered bird” (2009: 14, original italics). I encountered this pioneering medical spirit in the comments of several volunteers, such as an American medical student who remarked on how ‘getting to see goiters the size of footballs was

pretty cool.’ Similarly, an Austrian nurse told me that the medical volunteer experience was like “going right into our textbooks”:

It’s hard to find a TB case in Austria, so in some sense, I was eager to come here...to see what these places could show and teach me that I couldn’t learn at home...You see, we spend all this time with our mentors and they tell us, ‘Oh, when I was working in such and such place in the 70s, the cases we saw were so difficult...So, I came to see this, too.

Medical volunteers discussed how, beyond making them more employable through unique global health experiences, volunteering in resource-limited settings offered opportunities to practice skills and simple diagnostic techniques while learning about other medical systems and health practices. They experienced a need to “return to basics” when they found that taking patient histories involved more listening than doing (Eckhert 2006; Panosian and Coates 2006), and when they realized that, in many cases, listening was all they could do. Here, quite different from the state of medical exception I describe above, the “cloak of competence” (Wendland 2010: 20) that medical students often don to navigate their ambiguous and liminal status as students, but not yet fully qualified (or licensed) practitioners, is shed, with ears to the ground. On the last night before Harrison flew back from Simikot to Kathmandu, he reflected on what he learned about medical practice in Humla:

Watching [two of the local health care workers] interact with patients, on a professional level, it’s instructive. I mean, we came here to teach, but these guys are very, very, very good. They know their stuff, and they know the communities and the prevalent issues...that’s what GPs do, and it’s good to be reminded of that in terms of my own career.

Volunteers readily described these short-term opportunities as transformative experiences that offered critical periods for reflection, personal growth, awareness of privilege, and a reconfiguring of worldviews. On a personal level, medical volunteers described a spectrum of feelings during their stints, such as isolated, mute, angry, misled, mentally taxed, used, ready to go home, desperate for privacy, lonely, helpless and unhelpful, depressed, guilty, and aimless like a street dog. Several others expressed the desire—or at least, the musing—to leave sooner than originally planned. Yet, in the same interviews, volunteers would also express sentiments of

joy, excitement, wonder, gratitude, or comment on how much they learned during these enriching experiences.

Volunteers also confronted a plurality of ethnomedical systems in Nepal, which prompted, to varying degrees, individual practices of cultural humility. One German medical student mentioned how she had “begun to think about everything differently.” When I asked her to elaborate, she spoke passionately about her experience.

I mean, there is nothing romantic about poor people; nothing whatsoever. Poverty stinks. Poverty is ugly. It is dirty, stinking, itchy with bites and fleas and lice...by the way, I would love for you to check my hair before I leave...You cannot prepare for everything here, and the overwhelming feeling of despair. You know, how do you treat stinking, dirty children? Do you want to hold it? No, but then you realize that...well, yes, I will hold this child, because if I don't...[begins to tear], well, I have learned nothing.

Another volunteer reflected on her six-week stay in Nepal:

It's changed me, in such a short amount of time. That's what is so remarkable...staying with a family, eating with a family from a small plate has been a real privilege for me...All these things that we think we need, when we actually need very little. The biggest thing for me is how to become less ignorant, in my career as a doctor but also in my life...Why am I doing these things that I really don't understand?...I guess this is what Nepal offers, reflection.

### **Medical Volontourism and Local Economies of Hope: Mapping the Afterlives**

Then, let us do just that. Let us reflect on what short-term medical volunteer work tells us about prevailing models of short-term care, and what this fleeting form of medical engagement leaves in its wake. In this chapter, I examined the active and ambiguous social and political (after)lives of medical volunteers who circulate in and shape local economies of meaning and material realities. I have also shown how medical volunteers, themselves, are transformed personally and professionally by these experiences, which is perhaps a somewhat inevitable afterlife of these trips. I do not presume that the stories of international short-term medical volunteer work I describe above must ring true. Nor are they necessarily generalizable to other groups of

volunteers, NGOs, local health care workers, or recipient communities; though, it would not surprise me if this were to be the case.

Nevertheless, the voices and experiences I've re-presented above highlight some of the ethical complexities and effects—medical, social, and biopolitical—of short-term medical volunteer work in remote Nepal. These stories represent one form of an emergent “global health narrative,” where flying in doctors, medicines, and surgical equipment—even in the short-term—to ‘out of the way’ places and populations represented as ‘sick and poor’ is seen as the humanitarian obligation of the privileged towards the less fortunate (Wendland 2010: 9). We might now begin to see the “obligation,” itself, as a privilege, and as a byproduct or condition of this kind of short-term care in the contemporary circulations of short-term medical workers who shape local conditions of healing and hope.

As a form of short-term care, these medical encounters are often touted as “better than nothing.” Throughout the remainder of this dissertation, I will argue that this aphorism ends up looking more like an excuse upon which the management, rather than the confrontation, of different forms of inequalities in access to and control over the basic material and nonmaterial resources that promote and sustain health and wellbeing are based. Prime among these resources is hope for improved life chances. In one of the epigraphs in the introductory chapter, I quote Bajjir Bishwa Karma, a farmer in one of the villages in southern Humla where I lived and conducted research. He notes how foreigners come in helicopters to help because ‘here there is nothing,’ and adds how in their coming and going, they only leave ‘crumbs of the cow’—what he metaphorically refers to as the fine stream of milk flowing out of the teats, over which the less fortunate are left to fight. Let us take this statement as more than just a locally appropriate gastronomical metaphor, and see it for what it really is: a declaration of discontent, a hungering to know the worlds from where the stream of medical volunteers also “flow”; for, apparently, in those places there are people with medicines and food to spare.

Here, I'd like to briefly address the language of “flows” that has come to characterize discussions of global movements of people, ideas, technologies, and other resources. As Ferguson (2006: 47) suggests, these are poor linguistic terms to trace the ways in which the benefits of development and globalization, and in this case medical volunteer work, are distributed. Far from spreading out across the globe in contiguous ways, these projects “hop” around, effectively connecting certain points while systematically excluding others, leaving the

latter in what Ferguson (2006) has termed the “global shadows.” In the case of mapping the effects and afterlives of medical volunteers in the Hidden Himalayas, we see how even the connections made by imperfect global health care chains may be fleeting and inappropriate. These links may end up demonstrating to those who are the purported beneficiaries of these connections that they—here—may never reach/know/experience what’s on the other end—there.

Still, in the context of Nepal’s ailing health care system, perhaps the support provided to local health care workers and communities by volunteers in the form of encouragement, supplies, training, and direct medical services may be one positive afterlife. The value of simply showing up to help communities—what I have called the “placebo effect of presence” (Citrin 2010)—should also not be overlooked. As one scholar points out, these communities “realize that ibuprofen and multivitamins are not a panacea for inequalities in global health” when they thank medical volunteers for their time and effort (DeCamp 2007: 23). They are appreciative, the author continues, because of the hope that others care about them, and might continue to do so. Not surprisingly, medical volunteers do care. They were sensitive and concerned about the issues discussed above; about the monumental challenge of improving global health care inequalities; about the effects and unequal benefits of their own circulations; and about how their presence helped to merge the idea of foreignness (whiteness) with health and wealth.

Medical volunteers began to think critically in these ways as a result of their experiences. They began to draw causal pathways and connections between the historical, and increasingly transnational, socio-cultural, political, and economic factors that influence health and health care seeking beliefs and practices. These kinds of connections are crucial in the formulation of a critical global consciousness, and for inculcating in future medical practitioners conceptualizations of health and wellbeing that extend beyond purely medical domains. This, stands in sharp contrast to the typically “individualistic, mechanistic, decontextualized, and depoliticized explanations northern medical students learn” (Wendland 2010: 22). One American medical student mentioned how “this [volunteer experience] has made me realize that I need to go home and study public health.” In the words of another, these experiences will likely contribute to making volunteers “more critical and compassionate practitioners abroad and at home.” It strikes me that this critical consciousness—nascent as it may be in returning volunteers—is one afterlife of short-term medical work that seems rather positive, and one that I think Paul Farmer would strive to convey himself. In his own words (Farmer 2003: 41): “Case

studies of individuals reveal suffering, they tell us what happens to one or many people; but to explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy.”

In the mid-19<sup>th</sup> Century, the physician and anthropologist Rudolf Virchow presciently recognized that access to life resources were governed by unequal political economic structures, drawing a direct link between social inequities and health outcomes (Mackenbach 2009). “The improvement of medicine,” he wrote, “would eventually prolong human life. But, the improvement of social conditions could achieve this result now more rapidly and more successfully” (Ackerknecht 1953, cited in DeWalt and Pincus 2003). The challenge for short-term medical volunteers, then, is to find ways to contribute to these nonmedical goals, to follow in the analytic tradition established by Virchow and be, as he articulated, a “natural attorney for the poor.” As Paul Farmer has asked: “Where are the Virchows of modern public health” (1999: 34)?

Finally, I would be remiss in not returning to highlight the many medical volunteers I met whose comments and discussions challenged me, and forced me to continue to struggle over many of the ideas discussed above. While conducting this research, I met dedicated volunteers whose outlook on the determinants of health, health care, and global inequalities were realigned by their volunteer experiences. A few of their comments continue to stand out: “I can’t help but wonder if I’m treating hunger pains here,” as Adrian said to me. The other volunteer returned from a long day of working in a rural clinic and reported, “How do I tell people that their chronic pain comes from a life of chronic work, which they can’t stop because their livelihood depends on it? I just feel like I’m doing Band-Aid medicine.” Another *bideshi* doctor working in Kathmandu told me that it had been suggested that he had “lost his way” when, after returning from a volunteer stint in Humla, he turned down the request to volunteer at a health camp just outside of the valley with another INGO.

And there will be more offers from people doing other camps. I’ve seen and heard of at least five camps going on in October, of course, they don’t do it any other time. You know, very experienced doctors coming over, trekking and doing health camps, which are becoming more and more popular. It’s quite frightening actually, what people are doing. Are we...uh...what can I even say, are we doing anything? Are we giving them any hope? If you go back home and say, I volunteered at a health camp in Nepal, it looks great...But there’s a general lack of understanding in the population of what it involves and what effect it has. It’s better than nothing, that is

what they're saying, and probably what I used to think, as well. That's why I ended up going in the first place, but you soon realize that it's not that way at all.

I find these reflections instructive. They highlight the intricate relationship between food, labor, and health, which is often overlooked in purely curative frames. This forces us to shift our attention to focus on the lived, embodied and inextricable experiences of health, hunger, and hope. Lastly, they force us to disrupt the inappropriate binary of humanitarian help vs. harm— notions that are often incommensurable, unfixed, and embedded in different socio-cultural or medical systems.

In the next chapter, I explore health camps as a continued site of medical volunteer circulation and nongovernmental government, but also as an event where medicines are sought and given out as a valuable and meaning-filled aid commodity during the Maoist conflict. At health camps, Humli people's creative negotiations and strategies surrounding the movements, exchanges, and availabilities of medicines must be seen in the context of unmet basic needs, where life is uncertain and dangerous. Understanding the social and political lives of medicines—that is why and how Humlis obtain, value, understand, and use medicines—expands our understanding of their multiple meanings.

## CHAPTER FIVE

### **Health *C*omplications, and the Social and Political Lives of Medicine(s)**

*Medicines can be exchanged between social actors, they objectify meaning, they move from one meaningful setting to another. They are commodities with economic significance, and resources with political value. Above all they are potent symbols and tokens of hope for people in distress.*

~ Whyte *et al.*, *Social Lives of Medicines*, 2003

*The people of Humla are doomed to die if they suffer from any disease, so there is a great need to organize a nine-day general health camp, or they will continue to die.*

~ NGO health camp report submitted to Nepal's Social Welfare Council

*The health camp, what a headache! What to say? We walked a day, waited a day with the pushing, and came back the same day. The doctor wouldn't touch me here [pointing to her side], he gave me white pills for my stomach and said go away... We waited six hours for this. My husband traded the pills for sugar, with our neighbor. What to say?"*

~ Lasya, 47, farmer, mother of four, and wife of a school teacher in Humla

### **Health, Camps, and the Meanings of Medicines in Remote Nepal**

While walking to the district headquarters of Humla from the neighboring district of Bajura in October 2007, I stopped at a small teashop beside the gushing, post-monsoon Karnali River to eat some *dāl bhāt*. A young Chhetri woman roughly my age ran the shop, and she sat watching me eat with my hands, both astounded at my proficient thumb and completely unable to hide her laughter as I scooped food in my mouth. As I ate, the young woman took out a dust-covered box from a nearby shelf and sat down on the floor next to her tiny daughter that looked maybe two or three, but who turned out to be five. She immediately started to cry, perhaps aware of what was to come. The mother pulled out a tinted bottle of medicine and tried to give her some using a metal spoon tied to her waist sash, but the child puckered her lips and shook her head in defiant refusal. "*Khā khā*," she urged, "*Nikkāi hunchha*" (Eat, eat. It will make you better). As the child

squirmed, she played with her shirt, lifting it over her head in an attempt to hide her face. I saw there were several circular burn marks on the child's body from where a *dhāmi* (Nepali: "shaman") had burned her with a hot stick during a healing ritual to exorcise malevolent spirits that were causing physical pain or sickness, a practice known in Humla as *bāto hāl̄nu*. "*Āmā pani kāne, her,*" (Your mother takes them, too, look), and the woman began to sip the liquid she poured into the cap of what I could now see was a bottle of Amoxicillin suspension. Her child was pleased by this and obliged by putting the cap to her lips and tasting some of the syrup, looking at her mother for approval and letting most of it dribble down her chin. The woman then took a tablet from three separate plastic strips and threw her head back to get them down her dry throat. I don't know how she swallowed them. "Your mother takes medicine, too," she repeated, neatly placing the bottle and tablets back in the box, and storing it back on the shelf.

At the time, according to my field notes, I viewed this as "a social performance for my benefit," casting this woman rather reductively in this situation as someone simply enacting the consumption of medicine. I wrote:

*She wanted to show me that she knew that medicine was important for producing health, perhaps because I saw the burns by the dhāmi, and perhaps because I come from a place where people are thought to use medicines like the tablets and amoxicillin instead of going to see a dhāmi...How to stop the spread of the idea that medicine is what people need most here, because really it is already here.*

I then went on to mention the potential for antibiotic drug resistance as a potential concern in Humla because of the "gaps in understanding basic science." I seemed focused on the use of medicine in an interpretive context at that moment, as well as the larger implications for conflating health and health care in places where other basic needs are not first met. But, I was not seeing *how* and *what* the medicine meant in several other contexts. One could just as easily see the consumption of medicine as a social act, not necessarily as a medical one, that conveys something about the perceived and real social and economic differences between me and her, between my world and her world—here and there. Taking medicine could have been a demonstration of this young woman's awareness of the disparities in our ability to access medications, for in Humla, medicine is not easy to acquire. It might have been a demonstration of her knowledge of appropriate ways to care for her daughter's health from a western health care perspective so heavily dependent on taking medicines. Here, the larger social act of

consumption may take place in swallowing the idea that medicine is what causes health. Taking medicines might also be an active denial of some form of abjection from a larger global population who is at least perceived to be regularly taking medication in order to be healthy, educated, and modern. The social lives of medicine I am concerned with in this chapter surrounds these issues—the movements, meanings, and uses of health camp medicines sought out and obtained by different actors, for different reasons, in different contexts.

Over the course of eating lunch, I learned that the woman had never left Humla. She told me about her husband who had brought the Amoxicillin home from India, where he had spent a few years, periodically returning with money, cartons of cigarettes, and a radio that sat covered and unused in the corner on a table. He had gone with some other men from a nearby village who were also getting away from the Maoist conflict, and knew of jobs as “unloaders” (she said in English) where one could move goods off the backs of trucks and make good money. As for the strips of tablets she had eaten, she received those at the same health camp in Humla’s district headquarters that I helped coordinate the year prior in 2006. She had gone to this camp with her husband who, having just returned from his job as an unloader in India, was pressured by Maoist soldiers to donate some of his remittances to the party; or, she said, he could come join them as a porter instead. He refused both options, and the Maoists took him out of the house and broke his left leg with one swing of a rifle. I told her I was also at that health camp, and she said she knew: “*Malāi yād bho,*” (I remember you). My own social afterlife became a presence in the conversation, and I then saw another dimension to why she and her daughter might have been taking medications in front of me. To disabuse her of thinking I was a doctor, I told her about my research and why I was headed to Simikot. I also asked about her experience at the camp, as I would come to ask hundreds of other Humlis during my research:

When a health camp comes it is very good because there is no doctor here and the *bideshi* doctors know a lot and have very good medicine... We have nothing here, so in this view the camp is very good. My husband received good medicine at the health camp for the pain in his leg... Look at our daughter, she is small but she is doing fine. But you see [showing me her daughter’s belly] we also believe here in the *dhāmi* because they know if a person is suffering from a ghost (*bhut lāgyo*) and those bad things. For that, you don’t go to a health camp.

I believe her comments reveal several important ideas. They point to the aura of efficacy that surrounds foreign medical doctors and foreign medications, as discussed in the last chapter. Yet,

they also highlight how healing patterns of resort in Humla are deeply embedded in plural medical beliefs systems (discussed in chapter two). Attending health camps for broken legs and seeking traditional healers to deal with malevolent spirits are complementary practices in a broad, syncretic medical-cultural repertoire that is accessed for different reasons, at different times, in different places. And, as I discuss below, *dhāmi* continue to play a role in the interactions and negotiations with medicines at health camps. The woman's comments also point to several distinctions that so many Humlis make. The first is the distinction between the "here" of Humla and the imagined elsewhere of those who bring health camps and medicines. Perhaps she imagines that "there" young girls are not undernourished, as her daughter indeed was. The second distinction is a double one that involves the context of "nothing" (no permanent doctor, no regularly open health posts, no steady supply of medications) against which the woman deems the camp "very good," and against which the continued use of "better than nothing" health camps are often justified by those who conduct them.

The health camp has become a powerful and prominent model of short-term care in Humla, and acts as another node in contemporary global health care chains where medical personnel, ideas, and resources land briefly. Camps are sites where NGOs assume the basic functions of the state through the provision of health care services and essential drugs, embedding expectations of episodic care through intermittent service delivery. These camps are examples of what Malkki (1997: 87) refers to as a "transitory phenomenon"—an extraordinary, but unstable, place or event where brief but intense periods of intentional interaction create accidental communities of experience. At health camps, these intentional medical communities are made up of volunteer clinicians from abroad, students of medicine and health sciences, Nepali health care workers, I/NGO staff, and Nepali villagers. It is a fleeting event where a complex array of global, national, and local ideas and practices surrounding health, wellbeing, and healing interact, and from where multiple relations stream, and linger.

As I illustrate below, Humli people's motivations for and experiences of attending health camps vary because the camps occupy socio-political and health(care)-related spaces and needs in rural Nepal, and do so at a particular moment in Nepali history: during and after a decade-long civil war. Despite their fleeting conditions and uniqueness of circumstance, camps leave social and material traces and afterlives. These permeate and seep back into NGO reports and representations used to attract funding and future foreign volunteers to heal in Shangri-La. They

also (re)shape the perceptions and practices of all those involved in these episodic interventions, dispensing not only medications but ideas about social relationships and possibilities both locally and globally. The health camp, then, is an event that “presumably begins at some point and ends at another. Yet, more often than not, those points prove remarkably elusive” (Hoffman and Lubkemann 2005: 317). This chapter locates and traces some of those points.

Health camps, of course, are also sites for the acquisition of medicines, which are aid commodities that come to have values, meanings, and uses beyond those immediately associated with the treatment intended by those who provide them. As we asked for the meanings and values associated with the presence and circulations of medical volunteers, how is the movement of increasingly mobile medicines shaped by social relations and, in turn, how do medicines shape these relations (Whyte *et al.* 2003: 9)? Trostle (1996) has noted that doctors often use the prescription of pills to signal the end of a therapeutic encounter, but health camp medicines, and the social and material meanings and practices surrounding them, extend beyond such ‘discrete therapeutic events’ (Csordas and Kleinman 1996: 9). What is often “encapsulated” in obtaining medicine for camp attendees is the chance to connect to those who demonstrate concern, to legitimize sickness and bodily discomfort, and to take control of the tenuous conditions of everyday existence, especially during times of war.

Medicines also become useful resources sold for money. They are used in plural forms of healing, or given as a gift to someone too sick or busy to attend the camp. And, as we saw with the family stopped on the way to the health camp in chapter one, medicines are paid to Maoists who extract “tablet tax” for safe passage during a People’s War. As Whyte *et al.* (2003: 89) aptly note, medicines become powerful objects when life is uncertain and dangerous. In this chapter, I show how considering the social and political experiences, traces and afterlives of health camps transform our understanding of the meaning of medicines in situations of structural violence and unmet basic needs.

In the next section I cover necessary historical terrain by discussing the emergence of medical camps in South Asia. I divide the discussion into two parts. In the first part, I briefly trace the sinister origins of the medical camp model to family planning programs in India in the 1970s. In the second section I contextualize the emergence of health camps as a paradigmatic model of short-term medical intervention used by NGOs, the state, and military cadres in Nepal’s changing health care system. I then turn to an ethnographic discussion of health camps in Humla

both during and in the wake of the decade long Maoist People's War (2004 – 2010), and focus on the social and political lives of the camps and the medicines distributed there. As events where medicines are sought out, distributed, discerned, and traded—but done so in non-predictable ways—health camps represent sites of both ambiguity and possibility. I propose that the strategies used by health camp attendees—Nepali villagers, plain clothed Maoists, local Nepali health care workers, and Nepali medical camp volunteers—to stock up on health camp medicines can be approached in three useful ways: (1) as part of a universe of healing modalities that includes, among other syncretic modalities, local systems of faith healing, religious practices, and the use of informal home remedies, such as *jaDibuti* (medicinal herbs, seeds, roots, flowers, and plants); (2) as intentional acts of de-medicalization that defy the subjectivities ascribed to them by humanitarian groups as sick, unknowing villagers in desperate need of biomedical care; (3) and as the pursuit of a multi-purpose commodity through creative and improvised strategies in the context of basic needs unmet and redefined in settings of structural violence. Considering the active and dynamic social and political lives of health camp medicines in these ways, and within the range of active responses to sickness and other forms of suffering, expands our understanding of how and why medicines are sought, used, and understood to be meaningful commodities at health camps.

## **Tracing the Emergence of Health Camps in the Region**

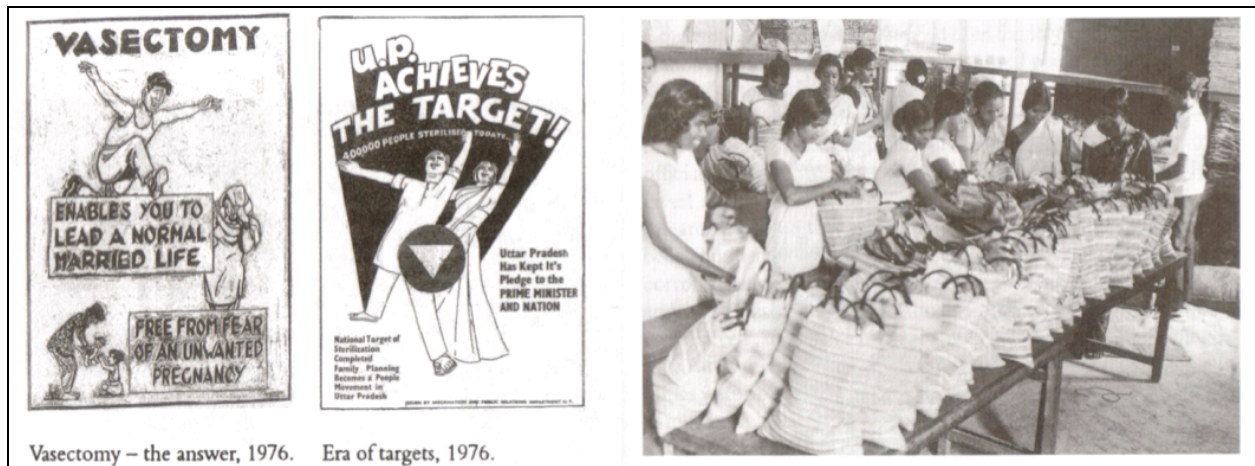
### ***Revisiting a Sinister History of Medical Camps in India***

*There were several worthy sons the country produced in the past...  
Many more worthy sons were yet to be born  
But, alas! Family Planning was introduced  
And, Effectively!*

~ Vinod Ashrumali, *The Wonder of Family Planning*, 1989

Historically, models of medical care have emerged as symbolic institutions at particular political economic moments, as “certain social classes and interest groups at all levels...stand to benefit, both ideologically and politically [and, of course, economically], by promoting particular models

of health service provision” (Morgan 1993: 3). In Nepal, pharmaceutical companies, privatized doctors, politicians, and elites at all levels rank among those who most evidently stand to gain. However, there are many forms of “power and domination to be had from defining a population as ‘sick’...and in need of the ‘doctoring’ hands of a political administration that swathes itself in medical symbols” (Scheper-Hughes 1992: 202). One need only recall Indian Prime Minister Indira Gandhi’s declaration of a State of Emergency in the mid 1970s, during which she implemented her draconian policy of forced sterilization through family planning camps.



**Figure 5.1** Family planning posters from the 1970s: “Vasectomy – Enables you to lead a normal married life. Free from fear of an unwanted pregnancy” (left poster). “U.P. Achieves the Target! 400,000 people sterilized to date. Uttar Pradesh has kept its pledge to the PRIME MINISTER AND NATION. National Target of Sterilization Completed, Family Planning Becomes a Movement in Uttar Pradesh.” (right poster). Gift baskets given to sterilization “acceptors” (far right photo) (Source: Tarlo 2003).

A 1972 article in *Studies in Family Planning*, entitled “Kerala’s Pioneering Experiment in Massive Vasectomy Camps,” describes a one-month long “Family Planning Festival” that registered 78,423 “acceptors”—the passive name given to people who undergo sterilization. “The Ernakulum camp,” boasts the article, “demonstrates that large masses of people can be motivated to accept sterilization in a short span of time by an organized and concerted effort” (Krishnakumar 1972: 177). Along with the terror imposed through sterilization came plans for the resettlement of those who had accepted. Widespread speculation arose throughout India as to whether the synchronized plans to forcibly sterilize and resettle—in the name of ushering in a new “politics of discipline and development”—were in fact part of the government’s methodical

plan to wipe out entire segments of the population, mostly the poor (Gupta 1977: 85, as cited in Tarlo 2003: 37):

People were rounded up at random, from streets, the teashops, and the bazaars, and taken to the family planning camps to be sterilized. No distinction whatsoever was made between old men and young boys, between married and unmarried—the forced sterilization just went on and on.

Rohinton Mistry's (1995: 520-1) historical novel *A Fine Balance* offers a wrenching portrayal of life during the *āpat kāl* (state of emergency) in India at the time, and of the fates of those who were taken to the sterilization “festivals”:

The sterilization camp was a short ride from town. A dozen tents had been pitched in a field on the outskirts, where the stubble of the recent harvest still lingered. Banners, balloons, and songs identical to those at the marketplace booth welcomed the garbage trucks. The passengers' terrified wailing grew louder as the vehicles were parked in an open area behind the tents, alongside an ambulance and a diesel generator.

The ease with which familiar Indian public servants—such as teachers, doctors and nurses—so straightforwardly enforced these policies through already existing state structures and delivery institutions—at health posts, clinics, and hospitals—is disquieting. As Tarlo (2003: 82) aptly writes, “The grotesque absurdity of a government policy which explicitly encourages illicit deals in human infertility” confounds the imagination. The early collusion of so-called philanthropic foundations—the precursor to NGOs—must also be pointed out here. In 1976, the Population Council—created in 1952 by John D. Rockefeller III to advance global population control and, subsequently, sponsor of the journal *Studies in Family Planning*—lent support to Gandhi's use of police raids during the massive sterilization round-ups (Hartmann 1995: 254, as cited in Smith 2007: 13).

A 2003 article titled “The Sinister Targets of Indian Health Camps” documents the recruitment of women for fortnightly sterilization camps in northern Uttar Pradesh by local Auxiliary Nurse Midwives (ANMs). ANMs reported that, “to turn up empty-handed was to invite the wrath of officials” of the State Innovations in Family Planning Services Project Agency (SIFPSA), a USAID-funded project (Menon 2003). To be sure, this is an extreme case, but an enduring social life of the camp model. Nevertheless, that this form of duress remains—

embodied still in the fear of being rounded-up for health camps run by supposedly nongovernmental organizations in the name of reproductive rights—serves as a necessary reminder that the camp model, and the constellation of sociopolitical and economic relations surrounding it, still requires serious analytic scrutiny.<sup>89</sup>

### ***Locating Health Camps in Nepal’s Changing Health Care System***

With the technical assistance of the U.S., family planning services were established in 1965 during Nepal’s Third Five-Year Development Plan in an effort to curb population growth, which was seen as a major health problem and an impediment to modernization and economic growth (Justice 1986: 50). From the beginning, importance was given to permanent methods of family planning (Dixit 1995: 61), and by the mid 1970s sterilization for men and women was made widely available through outreach camps.

According to Nanda Shrestha (1988: 211), the government ran yearly sterilization camps in Deurali, “mobiliz[ing] all of its resources, sending volunteers to every eligible couple’s house in the *pānchayāt* to coax them to come forward for vasectomy or sterilization.” Just as these “motivators” were paid “per client served,” financial incentives in rupees were part of accepting sterilization (Thapa and Friedman 1998: 79).<sup>90</sup> The money was meant as compensation for lost time from work and out-of-pocket expenses, but it is not hard to imagine that conditions of poverty might render hazy the line between want and need, and between coercion and consent. Opting to take control over family size, a desire to engage with allopathic medical services, and being in need of money are different motivating forces in the political economy of reproduction. These factors notwithstanding, forcible sterilization through family planning or reproductive health camps did not occur in Nepal as it did in India during the Gandhi administration.

Family planning camps have been touted as a major success in the fight to reduce population growth and fertility rates in Nepal (Thapa and Basnet 1998; MoHP *et al.* 2007: xxiv). Nepal’s 2006 Demographic and Health Survey found that one in five women “acceptors” obtained their method of family planning from mobile camps. Another study conducted in 1998

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<sup>89</sup> Harper (2002) has also documented police officials rounding up Nepali villagers who refused to attend Vitamin A distribution campaigns.

<sup>90</sup> From 1979 to 1998, this incentive remained steady at 100 rupees (Thapa and Friedman 1998:79), which, at the time of writing, is approximately USD \$1.40.

revealed that 77% (n=445) of Nepali women who received sterilization in hospitals complained of “regrets,” but the rate of regret for those who were sterilized at camps was considered an improvement at 50% (n=372) (Thapa and Friedman 1998). Thapa and Basnet (1998: 183) argue that a failure to provide these kinds of family planning services would demonstrate a lack of commitment to empowering women and improving child survival.<sup>91</sup> There is no doubt this is true; though, the experiential accounts of Nepali women who were sterilized through the outreach camp model would productively complicate the reductive binaries offered in the passive epidemiological language of “success” and “failure,” of “acceptor” and “regret.” More nuanced understandings of the interplay between cultural and structural forces impacting reproductive decision making and outcomes are required, including those that explore economic strains, access to services, inter-household gender relations, stigma and social threats, women's education and empowerment movements (Chapman 2006).

In light of the failure to extend equitable and consistent access to health care services into the remote and rural areas, medical camps have grown in numbers, size, (combinations of) medical focus, and frequency. In 1972, the Association for Ophthalmic Cooperation in Asia (AOCA), a Japanese NGO, performed 745 cataract surgeries in Nepal's first “eye camp.”<sup>92</sup> The following year's camp registered 978 surgeries.<sup>93</sup> Shortly after, ear, dental, uterine prolapse and other specialized camps appeared in Nepal. This process is part of what Stephen Bezruchka (2003: 30) calls the “organification” of medical care—the partitioning out of organs and body parts for specialized medical focus and intervention—and it represents a significant step away from the primary health care (PHC) efforts espoused in the 1978 Declaration of Alma Ata at the International Conference on Primary Health Care.<sup>94</sup> This important document acknowledged health as a human right; the relationship between poverty, political instability, and poor health; global disarmament as a policy measure geared towards freeing up resources; and the unacceptability of “gross inequality” in poor health status. One major weakness of the Alma Ata declaration, however, was its minimal inclusion of traditional healers in the renewed efforts to

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<sup>91</sup> These statements about empowerment and improving child survival indicate very specific turns in development discourse that emerge at specific historical and political economic moments, which deserve attention beyond that which I pay them here.

<sup>92</sup> Perhaps using a contemporary phrase in historical retrospect, Dixit (1995: 16) has suggested that the first eye camp was actually held in 1947 shortly after Mohan Shumsher became Prime Minister and invited some doctors from India's Sitamarhi Eye Hospital to examine his own eye problems.

<sup>93</sup> Available at: <http://www.aoca.jp/e-aoca-sub11.html>. Accessed 02 March 2010.

<sup>94</sup> The declaration can be accessed at: [http://www.searo.who.int/LinkFiles/Health\\_Systems\\_declaration\\_almaata.pdf](http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf)

meet people's basic health needs and overall wellbeing from a holistic perspective. The declaration only offers a backhanded "as needed" in regards to these practitioners' inclusion in the new approach to community-oriented health.<sup>95</sup> Yet it achieved a separate milestone by ranking specialized medical services and the use of drugs behind a list of preventive components aimed at achieving "Health for All by the Year 2000"—behind education, food and nutrition, sanitation, and clean water. In short, the concept of health was situated firmly within larger struggles for social justice.

The same year as Alma Ata, Nepal's Institute of Medicine (IoM) enrolled its first medical students from all over the country. The hope was that they would return to their rural homes upon completion to work in the health, sub-health posts, and district hospitals that slowly spread throughout the country. This met with modest, but fleeting, success. Part of this related to the fact that the degree granted after graduating from the IoM was a medical science diploma of the doctor of general and community medicine (MSDDGCM). There was great concern from the beginning that the community-oriented nature of the medical training and the odd title would produce "a second class of medical manpower" (Dixit 1995: 179) and not allow "upward" (read: urban or international) mobility. This degree was done away with when faculty at the schools began to push for internationally recognized credentials that would allow them—as well as their sons and daughters coming up through the ranks—to go abroad.<sup>96</sup>

In 1987, King Birendra's "basic needs" program sought to build on the Decentralization Act of 1982 by integrating and devolving certain powers to rural health care centers. "The major bulk of our people live in the villages," he said. "It is only fitting, therefore, that priority in our long-term health plan should be accorded to the rural development scheme" (cited in Stone 1986: 294). PHC efforts in Nepal resulted most visibly in a vast network of village health workers (VHWs), community health leaders (CHLs), and Nepal's renowned female community health volunteers (FCHVs), who made regular home visits in the areas they lived. Family planning remained a cornerstone of PHC in Nepal, and the task of organizing villagers for immunization and sterilization camps was given to VHWs (Stone 1986: 294).

Few could argue, publically, against a need for comprehensive, community-based approaches to addressing people's health and health care needs. But, the realities of reducing the

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<sup>95</sup> I am thankful to Gregory Maskarinec for pointing this out to me.

<sup>96</sup> This information came from personal communication with two sources who requested to remain anonymous.

power and privilege of the elite, and of more equitably redistributing resources in hierarchical countries in order to do so, proved difficult (Heggenhougen 2009: 182).<sup>97</sup> In the 1980s, financed by World Bank (WB) Adjustment Credits and International Monetary Fund (IMF) Structural Adjustment Programs (SAPs), “tied aid” proceeded in Nepal—much like it did elsewhere—largely according to the conditions of the donors. However, *pānchayāt* rulers and subsequent governments that emerged after the 1990 *Janā Āndolan* viewed the aid as free money, and therefore must also be held accountable for ushering in these policies. And, since they did not have to pay the money back personally, they had little interest in “killing the goose that lays the golden eggs for them” (Shrestha 1993: 19).

Structural Adjustment Programs capped public expenditures spent on health care and further steered medical services towards the private sector, in turn, weakening national health care systems. In line with the neo-liberal drive towards free-market policies and privatization, a range of institutions and foundations moved in to finance the switch to selective care. NGOs were promoted to fill the gaps in public services that resulted from reduced public spending (Pfeiffer 2003: 726), with international NGO-disbursed ‘development aid’ increasing tenfold between 1970 and 1985 (World Bank 1995:40, cited in Ahmad 2006: 187). We can see the impacts of this on Nepal’s health care sector. In 1995, Dixit wrote that, while “some health services are provided by NGOs, health care delivery is by and large a government affair” (146). This is no longer the case. Nepal has seen an exponential growth in I/NGOs of all kinds—from 193 in 1990 to figures some put near 50,000 (Dhakal 2010; Khanal 2006; Shah 2008: viii; Social Welfare Council 2009). To be sure, a focus on projects reveals that a much smaller proportion of them are consistently active, and even less mobilize foreign funding to implement projects. Still, NGOs become inextricably entangled in local politics and, in many parts of rural Nepal, begin to take over the most basic functions and powers of a putatively absent state. NGOs—especially those working in the health sector in remote regions—have become part of the network of humanitarian assemblages that wield tenuous administration over survival within circumstances that do not favor it. Acting on particular bodies and minds, this is what Redfield (2005: 330) has termed a “minimalist biopolitics” (Redfield 2005: 330). This tinkering with life but not affecting the determinants of life chances complicates the “government of health” (Foucault 1994 [1973];

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<sup>97</sup> See Justice (1986) and Stone (1986) for excellent discussions on the difficulties that arose between planners, intermediaries, and the intended beneficiaries of rural health programs during the transition from Nepal’s Integrated Community Health Programme (ICHP) to a focus on PHC principles.

Rose and Miller 1992), where the assemblages of I/NGOs that engage in medical care—particularly short-term care—have both expanded and disaggregated the channels through which people have come to expect its delivery.

Humla district provides an example, where, as of 2010, there were 177 NGOs registered with the local District Development Committee (DDC) office—roughly one for every 270 people in the district.<sup>98</sup> According to a GHW in the district, “There is absolutely no coordination between these organizations. That is the biggest problem.” The mission statement of one NGO in Humla states that they were recently founded “to run the district health system for a period of 15 years.” This organization continuously rotates volunteer teams of *bideshi* doctors and nurses for short stints (discussed in chapter three) to work at health camps and in the district hospital. According to the NGO’s website, the Ministry of Health and Population also recently gave them permission to install one of their Nepali employees as the manager of the hospital under the supervision of the acting District Health Officer (DHO), which changes yearly.<sup>99</sup> Yet, “Providing health care where no one else can or will!” is the slogan of another INGO working in the same district—from which the abovementioned NGO had originally split after disagreements over staff, projects, and finances. Still, a third INGO operates health camps and medical volunteer programs within its private, three-building hospital compound with working equipment the district hospital lacks, such as an x-ray machine. For various personal, political, and economic reasons, which I don’t elaborate here, these NGOs have decided not to work together. In Humla, the expansion of “NGOdom” raises serious questions about the fragmentation of primary health care delivery (cf. Pfeiffer 2003: 726), and about these organizations’ abilities to respond to the needs of the national health system and communities they propose to serve through the increasing use of short-term health camps.

During the People’s War, fighting caused great difficulties in health care provision and access to services greatly contracted. Maoists shut down health projects, evicted NGOs, and ransacked health posts. The known use of road mines disrupted the flow of medicines throughout

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<sup>98</sup> Only a handful of these organizations are consistently active, and sometimes NGOs will register multiple times for a range of different inter-organizational projects.

<sup>99</sup> Here, the semi-official ‘contracting-out’ of the district hospital and its management is part of the MoHP’s attempt to foster public-private partnerships (PPP) in order to improve health care service delivery in underserved communities, and when cost effective (NHSP 2010: v-vi, 44). The government’s “intention is to achieve increased efficiency and effectiveness through more competition and performance-based contracts,” but it is unclear if this is occurring. The contractual approach to health care in resource-limited settings is a topic that requires further empirical research. See, for example, Soeters and Griffiths (2003).

the country, and many doctors and health workers fled rural posts. International aid dried up in light of the increasing political instability. Delivering medical services to people outside cities became increasingly difficult. As a result, the Nepali MoHP, the growing number of NGOs, and the Maoist and Nepali Army security forces continued to utilize more short-term approaches, like health camps. The short-term nature of their presence in settings where long-term unmet need exists is central to their complexity as ephemeral sites of care.

## **Health Complications: Medical Camps Amidst a People's War**

### ***The Anatomy of a Health Camp***

I begin with a description—a kind of ethnographic composite sketch—of a general health camp in Humla, as I have come to observe them and have had them described to me over the course of my research. Admittedly, it is a partial description, in both senses, but it is intended to offer the reader some idea of what happens at one of these camps, and to begin to ground the discussion in the voices and experiences of those who plan and attend them.

The camp's planning phase is filled with meetings, emails, and phone conversations between donors, directors, and volunteers, and they begin months in advance; though, much is beholden to contingency, left "up to a wing and a prayer," as the Nepali director of one NGO remarked in his description to me of camp planning procedures. The "Free General Health Camp" (*nishulkā swāsthya shivir*) with foreign doctors to be held at the district hospital is advertised roughly one month in advance over the radio in Humla and with flyers posted in health posts or distributed to Nepalis living near the district headquarters. Sheet-sized banners painted to publicize the camp are often hung over the walkways and paths that wind through the district headquarters. "We like to think we'll be ready," another foreign NGO chairman told me in an interview. "You know, we spend all year raising funds and giving presentations. We plan, plan, calling, emailing...I barely sleep some nights. But, in the end, we never are [ready]." Unpredictable weather in the Karnali region—especially during the summer monsoon months (end of May through September)—can often ground flights bound for Humla, stranding staff, medical volunteers and stores for up to a week in various parts of Nepal's Tarai. At a camp I

attended in 2004, during the first day the hospital registered just shy of 1,000 attendees, and almost half of the foreign and Nepali doctors and nurses were still stranded elsewhere, waiting for a break in the clouds. Conversely, one lab technician from a participating Nepali medical college in Nepalganj told me that he was given only a few hours notice before he was to report to the airport to fly up to the camp in Humla. But, perhaps in one of the most important examples of contingency, during a camp in 2006, the government health workers were on strike both before and during the camp. This prompted a good deal of fighting between local Nepali staff, government health care workers, and foreign NGO board members who were upset in the delays in their schedule, but realized they were supposed to be working in accordance with local health care institutions. “I don’t care about the foreign doctors,” Ram, a government health care worker, said. “This is our hospital.”

Readying a hospital compound for the camp requires much “prep work,” and so *bideshi* and Nepali volunteers often fly in to the district early. Some of the activities that health camp volunteers participate in include cleaning up animal droppings from inside and around hospital buildings; building temporary toilets with sheets and poles; cleaning bedpans, washing linens and making beds; preparing storage spaces for medicines and equipment and then logging them; scrubbing wooden and dirt walls and floors; and readying rooms for sterilizing equipment, examining, and performing surgeries. The “prepping” of health camp sites where short-term interventions of care occur involve not only “scrubbing” the walls of the inside of health care facilities, but also represent a symbolic cleansing of medical culture, where spaces designated for medical services are seen to go from dirty and inadequate to standardized and ready for care.<sup>100</sup> This can be seen as a ritualized act and a performance of a successful development project, which I discuss further below.

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<sup>100</sup> See Robbie Davis-Floyd’s (1994: 323-340) discussion of “prepping” the patient for childbirth in United States clinical settings as symbolic of the ritualized and techno-scientific standardization of this highly individualized experience.



**Figure 5.2** Before and after NGO volunteers cleaned the hospital for a health camp in 2004.

When the camp begins, Nepali volunteers register long lines of attendees through the windows of a centralized building. Attendees are then directed to one of the outpatient departments (OPD) where they form new lines, often wrapping around buildings, standing back to front while crammed against one another. At health camps, waiting for uncertain amounts of time is a certainty, though waiting is not an unfamiliar activity to Humlis. They are used to waiting, especially in Simikot, often for hours and sometimes days to have a paper signed by an administrator at the local DDC office, to see a health care worker or doctor at the hospital, or—as we see in chapter six—to wait in line for food aid. As Craig Jeffrey (2010: 3; see also Corbridge 2004: 184) has noted drawing on the work of Jean-Francois Bayart (2007), waiting has become a prominent, if not very new, feature of life for subaltern populations around the world. This includes both long and short-term kinds of waiting, for immediate material goods and services needed to address health and wellbeing, and for futures both extant and imagined. Waiting, then, is an act that structures aspirations and hope of their fulfillment.

When attendees finally reach the front of the lines, they hope to be examined by a Nepali or a *bideshi* doctor and prescribed medication. As discussed in the last chapter, in general there is a greater demand to be seen by a *bideshi* doctor, and in this case a translator is typically required. However, when Humlis interact with other Nepalis at health camps, instances of discrimination or disrespect are common. I heard numerous stories of visiting Nepali and Indian doctors

refusing to touch patients during examinations, as Lasya mentions in the epigraph to this chapter. At a health camp I observed in 2009, I saw two Kathmandu-based male gynecologists jokingly jostle with one another out of the room when several women entered the room for examinations wearing clothes that were very dirty. Another camp attendee, Shristi Rokaya described his interaction with a doctor from Kathmandu in this way: “The doctor said to me, ‘Untie your clothes and lift your shirt...’ We are like animals to them. In their thinking we are the dirty, low people, and we are all untouchable (*Hāmi sabai dum*).” These comments relate to differing ideas about the caste system and the overarching socio-moral, religious and cosmological system of hierarchies that dictates whom one may or may not touch. The caste system was enshrined in law until 1962 (Sever 1993: 86; see also Höfer 1979), though many Nepalis still adhere to its systems of stratification, admittedly or otherwise. This is one enduring social life of the health camp, though feelings of caste and class-based discrimination are not new, and Humlis regularly talk about poor treatment when presenting at any health care facility. However, as Harper (2003) writes, even when there is an expectation of being treated as inferior, any contact with a bureaucratic medical system may be seen as an avenue of hope, the opposite of despair, in the negotiation of the diagnostic maze in search of healing or relief from suffering.



**Figure 5.3** Long lines form early at “the mother of all health camps” in Humla, 2004.

A health camp examination is very brief, typically lasting no more than five minutes. The examination may result in any combination, number, and repetition of the following results, though the first three are the most common: (1) There is a diagnosis made, a prescription is written, and the patient is directed to the medical dispensary; (2) following diagnosis, the patient is determined to be “healthy” or presenting no clinically observable symptoms, and either sent away with no prescription, or they are prescribed tablets upon their own insistence (the medicines prescribed in these instances tended to be vitamin drops, calcium, iron, or antacid tablets); (3) the diagnosis is uncertain and the patient is sent to another OPD for an examination, x-ray, ultrasound, or blood test; (4) after one, two or multiple consultations and diagnoses, the patient is referred to surgery, which may happen that day or in a day or two; or (5) the patient is referred to the closest medical college, which is typically impossible for most camp attendees who cannot afford the flight (approximately USD \$70 round trip).

Health camp examinations, then, are experiences where touch, class, and caste intersect, shaping subjectivities and informing ideas and possibilities for health and health care. Locke and Scheper-Hughes’ (1987) concept of the “three bodies” is useful here in understanding the, embodied experience of waiting and of being examined, as camp attendees negotiate the lived bodily state of standing in long lines, potentially in pain and in search of relief from sickness or suffering, crammed against other bodies. The social body is experienced through the prolonged symbolic act of waiting, of being ordered, and examined, and through the inscription onto the larger community of camp attendees present that they are a ‘sick society’ in need of the healing by those who come from a supposed healthy society—elsewhere in *bideshi* lands, or in Kathmandu. The body politic is exemplified in the (re)making of docile, social bodies for control, management, and intervention—to be counted, ticked, managed, fingerprinted, and prescribed (proscribed). Only at the end, to be potentially told they need to fly down to receive care at a hospital a plane ride away, which all Humlis know they cannot afford.

### ***Camps for the People? Differentiating Between Medicines, Poisons, and Bullets***

At a health camp I volunteered at in 2004, the then-Royal Nepali Army patrolled the hospital compound with automatic weapons, stationed as a result of the ongoing Maoist conflict. Soldiers

were not there to control attendees, or to try and identify amongst the thousands of camp attendees possible plain-clothes Maoists trying to stock up on medicines, who were most certainly there. The presence of armed soldiers nevertheless contributed to the warlike atmosphere of the camp, as well as to the direct politicization of medicine brought by NGOs and foreigners from ‘class-enemy countries’ like the United States in rebel-controlled territory during wartime.



**Figure 5.4** Waiting at the camp, with police guard tower in back. (Source: NGO website)

During the conflict, the army and the Maoists ran health camps in order to elicit support from the Nepali people. This was especially true in remote areas, where violence and excess caused widespread distrust and resentment towards all those who “fought” or “defended” in the name of the people (Sharma 2004: 45).<sup>101</sup> In Humla, the Maoists had systematically implemented their “Whole Time” (WT) program through which they forcibly registered one person from each

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<sup>101</sup> The provision of medical care as a legitimizing tool of (often repressive) regimes or militaries is not new, nor is it a typically Nepali phenomenon. For example, the Pakistan Army conducts free medical camps to bolster its public image. The U.S., too, has become increasingly involved in humanitarian aid to countries with large Muslim populations as part of its ‘winning hearts and minds’ strategy in the wake of the incidents of 9/11 in New York. See, for example, Feinstein International Center (2010).

household (*'Ek ghar, ek comrade,'* One house, one comrade) as soldiers, porters, cooks, donation or information collectors, ideological outreach workers, and cultural program participants. As I've already mentioned, whole villages were implicated in the party in this way, making it difficult to turn away Maoists who snuck into villages in search of shelter and food in the middle of the night. The next morning the Nepal Army would come, pressuring villagers to explain these forced acts of hospitality, or provide information on Maoist sympathizers, sometimes also under the threat of violence. "First the Maoists come, then the army comes," one elderly woman told me, moving both hands together to imitate the action of firing an automatic weapon. "Then the tears come." She streamed her outstretched fingers down over her eyes to represent crying and shook her head. Navigating the complexities of being caught in the crossfire of war was one more way that people in Humla were forced to negotiate the presence of 'ambiguous occupiers'—either armed cadre or foreign 'do gooders'—in settings of chronic scarcity, and where life is uncertain and potentially dangerous.

Politics and medicine are inexorable in this context, where basic needs are unmet and meeting these needs basically uncertain. Running health camps was one way of demonstrating care for those needs, for being ostensibly "for the people," though people were savvy about the mixture of political rhetoric and medicine.<sup>102</sup> Vincanne Adams (1998: 194) documents the interplay of NGOs, health camps, and the promise of populist politics following the 1990 *Janā Āndolan* (People's Movement):

Villagers at the health camp expressed the opinion that if they towed this NGO's political line they would gain access to its privileges in the same way they used to obtain privileges from their local politicians. They had always known that loyalty brought rewards, and in the post-revolutionary context the system had simply been recast in terms of party politics and the work of NGOs.<sup>103</sup>

In *Forget Kathmandu: An Elegy for Democracy*, the Nepali author Manjushree Thapa (2005: 232) offers a personal account of contemporary changes in Nepal following the 1990 People's Movement, and writes of her experiences walking through the heart of rebel controlled areas during the conflict. One day she encountered a Maoist soldier, whose words capture the intentional politicization of health camps and medicine during the People's War:

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<sup>102</sup> For, really, are the two not really one and the same?

<sup>103</sup> See also Harper (2003: 33, 54).

[The army] conducted a medical camp in Pakha VDC, and they mixed poison with the medicine! ... Two children got sick... We told people not to go to the camps. Anyway, they don't want to go. They say—The army first comes and kills us, and now they want to treat us? We're not going to go to their camps. But the army's been forcing them to take poisonous medicine... People come to our camps because they know that we're working for them. They don't go to the army camps. At one army camp, the villagers even chanted against the army saying—We don't need medicine when we can't get justice!<sup>104</sup>

Traveling on, Thapa encounters other villagers who told her of the hardships of being caught in the crossfire of fighting, and of the separate armies' attempts to show that they “care” about villagers through offering camps while also subjecting them to indiscriminate acts of violence: “We don't need the government and we don't need the Maoists. Just let us go back to the way we were. We just want to go back to living off nothing. Just let us be poor” (Thapa 2005: 217). Here, poverty and being left alone is “better than something.”

A *Nepali Times* article entitled “Guns and Medicine” (Newar 2003) further illustrates how camps were drawn into the physical and political terrain over which Nepali Army and Maoist soldiers continued to battle:

The Maoists accuse the army of trying to probe their defenses... under the pretext of establishing a health camp. The army says the local people are in great need of medical attention... [and] the Maoists opened fire on the patrol while negotiations were going on about establishing the medical camp... Both sides agree on one thing: a civilian was killed in the crossfire.<sup>105</sup>

Like the idea of ‘medicine as poison,’ this scenario further adds to the ambiguous social and political lives surrounding the provisional use of medicine through episodic health camps in remote areas. That one of the words often used for medicine tablets in remote areas is *goli*, which also means bullet, seems a cruel irony here.

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<sup>104</sup> Another instance of ‘medicine as potential poison’ is described in *Mao: The Unknown Story*, where during the beginning of the Sino-Japanese war, medical humanitarian efforts by a Red Cross team were sent by the Nationalists to treat any and all in need of medicine. Mao's regime had set about spreading rumors that the medicine was poisonous, and it had been sent by the Nationalists to murder comrades, as well as put germs and other poison in water sources (Chang and Halliday 2006: 292).

<sup>105</sup> Politics and health camps continue to interact. In a 2009 article in the *Himalayan Times*, it was reported that cadres of Maoists had beaten a United Marxist Leninist (UML) official because “he had been running a medical camp without their permission.” CPN-UML leader thrashed. *Himalayan Times*, 15 September 2009.

## *Performing Health Camps*

Shortly after the People's War came to an end on paper in 2006, I had the opportunity to walk through parts of Karnali that I had never visited. Traveling to Humla from Bajura district with one foreign and two Nepali permaculture experts in 2007, we encountered a number of groups returning from a health camp. One middle-aged woman expressed the belief that NGOs ran health camps so that they can take pictures—she held up her x-ray—and write reports “to increase dollar collection” (*dollar collection baDHāune*). The man I took to be her husband expressed the opinion that they conducted them “for show” in such troubled areas (*yasto dukha bhaeko kshetrā mā dekhāuna/dekhawāti ko lāgi chalāune*). Others in the group made reference to them being like a “play” (*nātak*),<sup>106</sup> and that during the People's War,

NGOs work in remote areas like these to show how it is done...where nobody could do the work because of Maoist dangers. ‘In places where treatment could not be done, we did it. In the places that the government could not deliver, too, we did it.’ So, health camps are for show.

These comments draw out the highly performative nature of camps, and the generative social lives of representations of Nepali people made at these camps. The presence of Nepali and international film crews like the BBC also contribute to the politics of visibility for short-term models of care (cf. Harper 2002: 137) and the ritualized enactment of development.<sup>107</sup> This was crucial in Nepal during the Maoist conflict, as funds for projects were drying up as stories of Maoists sabotage reached donors. Camera crews photographed camp attendees as they waited in line, received treatment, and engaged with the equipment flown up by the volunteer doctors. These recorded moments are then used to make videos, and write reports to justify the need for continued intervention. An example is the report I quote in the epigraph to this chapter that seeks to crystallize the notion that Humlis are “doomed to die” without the presence of health camps. In one instance, which I happen to capture on film (Figure 5.5), I noticed a member of one of the foreign film crews asking a health camp attendee to hold up the x-ray of his pelvis he had just

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<sup>106</sup> And as Mottin (2007: 325) has pointed out, “Nobody wants to be labeled a group doing ‘NGO theatre,’ alternatively known as *vikāse nātak/vikāse kām* (development theatre/work).”

<sup>107</sup> The Nepali medical anthropologist Madhusudan Subedi has likened health camps to a well pulled-off catering job, where the ‘medicine is simply the food’ (personal communication, February 2010).

received. In doing so, he began to rotate the photo so it, too, had its feet pointing down, but the crew member stopped him abruptly with a, ‘Wait, okay, okay...Hold it like that...aaaaand, got it. Excellent,’ and it slowly dawned on me what this photographer was after: a shot of the man holding the x-ray upside down. Representations of ‘backwards’ villagers with little knowledge of technology and anatomy are created at camps, and they live on in images such as these, which find their way back to pamphlets, websites and reports used to fund more health camps and attract medical volunteers to Shangri-La, clearly beautiful, but in a state of medical disrepair.



**Figure 5.5** Performing health camps: Nepali and international film crews contribute to the performance of care at a health camp in Humla. (Source, NGO website)

Camera crews also film the opening and closing speeches made at health camps, which are typically delivered by local politicians or other *Thulo mānchhe* (Nepali: “big people”), reciting the mantras of development (*bikās*) and empowerment (*sashaktikaraN*). NGOs often remind its foreign staff, that in order to appease donors and Nepal’s MoHP, their work must be viewed as collaboratively “supporting” the DHO staff, and in no way independent of mutually agreed upon goals or local politics. At play here is a complex politics of visibility and acknowledgement that dictates who appears to be in charge, who needs to be in charge, and who needs to appear as though they’re in charge. As such, these visits are choreographed presentations that contribute publically and politically to the social production of successful NGO initiatives. As David Mosse (2005: 166) notes, “The more influential the visitors, the more formal, structured and shorter the visit, the more impenetrable the displayed public face of project rationality.” However, in a

candid interview, one NGO director spoke directly to the “messy” nature of running health camps during the People’s War:

When we looked back at the results of the camp, we’d felt it was a big to do, and it had been very difficult to run, an awful lot of unmanageable politics between NGOs, participating parties, the UML, Maoists, the CDO [Chief District Officer]...Flying in doctors who had totally different aspirations and intentions as to what was the basic needs of the community...it’s just a mess. All of that left us totally disillusioned [with] such an expensive event, very hard to deliver any real health benefit through them.

As I already discussed, the benefits of health camps—like the efficacy of the drugs dispensed there—are difficult to quantify or measure. Cross-sectional or longitudinal studies of drug “compliance” among health camp attendees, or analyses of other effects of health camps as medical events that directly impact health outcomes do not exist. Studies of this nature may be useful in monitoring and evaluating health camp outcomes, if locally appropriate criteria for ‘positive’ and ‘negative’ outcomes can be established. But, I dare say that may be more difficult than possible, or productive. It indeed seems more cogent to recognize that health camps will inevitably be used by a variety of actors—some present, some not—in a plurality of ways to meet a range of needs—some medical, others not, all rooted in the conditions of everyday life in Humla.

### **Plural Forms of Healing and Intentional De-medicalization**

Health camps are sites where the medicalization of health occurs through the overeager and often-haphazard distribution of pills a week at a time, despite the fact that camp attendees typically present with chronic ailments that stem from the difficult conditions of living in the remote mountains; from poverty, unclean water, and inadequate food. These conditions simply cannot be addressed with short-courses of drugs.

Scheper-Hughes (1992: 200) has written poignantly on the “magnetism” and “charisma” of drugs to “relatively isolated populations.” But, medicines are not being “pushed” on Nepali people at health camps. To say so would misconstrue how the “charisma of medicines” interacts,

and is forced to change, with everyday ideas and flexible practices surrounding their meanings, values, and uses.

Health camps attendees engage the availability and efficacy of medicines using a variety of fluid and sophisticated explanatory models and illness etiologies. These plural healing practices are rooted in an enduring mix of Hindu-Buddhist-shamanic-animist practices in Karnali. These healing modalities—including what Humlis know or do not know about biomedicine—are brought to bear on the experience of attending camps and in the use of medicines obtained there. It seems appropriate to view the syncretic and adaptive practices that surround seeking out, obtaining, and using medicines received at health camps as part of the active social and political lives of medicines, as the confirmation of sickness or suffering, and as intentional acts of de-medicalization.

At a general health camp I attended in 2010, I noticed several camp attendees seated beside a stone wall located behind the district hospital compound, laughing, sharing pipes of tobacco, and pouring steaming liquid from a plastic thermos. They also ate some food they brought from home—different medicine—small pieces of fried goat meat and millet bread, which they unwrapped from the paper-thin pieces of beige birch that Humlis often used for this purpose. I approached the small group, who had begun to point when they saw me, shoving and laughing now harder. One elderly Thakuri woman grabbed a middle-aged man’s X-ray that he had just received and waved it at me, cackling, and they wrestled a bit before he managed to snatch it from her hand again. “Give the doctor some tea,” the middle aged man said as I sat on the ground beside them, and he moved the plastic bag he was seated on under me. I told them I wasn’t a doctor, to which another elderly woman replied, “You look just like a doctor.” My irremovable marker of foreignness was my white skin, which—at a health camp—might as well have been a white lab coat.

The tea I was offered was not milk tea (*chiyā*), commonly served to guests, and this group of attendees apologized for this. Apologizing for foodstuffs offered to guests, particularly *bideshi* ones, is a common practice in Humla, and one that I discuss in chapter six. The tea was made from a local herb known as *ghoDā morchha* (Nepali: lit., “horse chili”; *Thymus linearis*)<sup>108</sup> and mixed with local bee box honey, which cut the tang and spice of the tea and left it sweet and viscous, tiny purple leaves and stems swirling at the bottom. The raucous elderly women then

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<sup>108</sup> See Ghimire *et al.* (2008: 88, plate 24).

took two small capsules out of her pocket and opened up the plastic coatings, pouring a little of the grey pill powder into her tea, then the middle aged man's cup, before closing them back up again. They stirred the cups with their fingers. When I asked why they were mixing the two together, another younger woman who had not yet spoke since I sat down said, "*Yesmā dubāi hāmro āushaDi timro āushaDi pani*" (It is both your medicine and our medicine). The elderly woman loudly sipped her tea and, smacking her tongue from the roof of her mouth, said vociferously, "Yes, this is our medicine. We know little about [Western] medicine (*bideshiko āushaDhi*), but it can be too strong (*sāhrāi kaDā*). We are uneducated, we did not go to school, but we learned about *jaDibuti* [the use of medicinal herbs, roots, flowers, and plants] from our ancestors since we were children." And, they sat and drank this mixed medicinal tea, blending worldviews and medical practices, simultaneously participating in healing as prescribed by local medical beliefs and consuming first world ideas of biomedical efficacy, if only just a bit.

Other examples of plural medical practices were present at health camps. Local faith healers commonly attended, sometimes seeking medical attention for their own ailments, but also because camp attendees request their services. For Humlis, If an aura of magical efficacy surrounds *bideshi* medicines (Harper 2003; Maskiranec 1995: 93), then who better to intervene in their use then shamans who regularly act as intercessors to local supernatural worlds.

On several occasions I saw *dhāmi-jhānkri* (the two words are often used interchangeably to mean shaman) blessing pills handed out at the camp dispensaries, making them, as one told me, "easier/softer" (*sajilo*) to eat by reciting and blowing mantras over them. I also saw a *dhāmi* sorting through a cluster of capsules displayed in an outstretched hand, arranging them based on sizes and shapes, removing the red and pink ones and giving them to a young boy standing beside him. "These are too warm for the body," he said. "The body is already hot in these summer days. This is not good for health." Here, *dhāmi* work with camp attendees to identify the appropriate medicines in accordance with naturalistic ideas about diet and balance of body temperature, which were parts of local therapeutic modalities known to all Humlis.

Health camp attendees engage these plural beliefs to evaluate the socio-physical properties of drugs, as well, and these properties are closely tied to expectations and practices surrounding their use and efficacy (Bledsoe and Goubaud 1985; Nichter and Nichter 1996; Senah 1997; Whyte et al. 2003). In my conversations with attendees, I heard references to "cheap pills," "useless creams, like toothpaste," "the inauspiciously colored pills," "pills my

grandmother refuses to take because they make her cold,” “original” and “fake” medicines, those from India, China, and *bideshi* medicines. “*Bideshi* medicines are mostly chemical, so they are dangerous,” was the response of one elderly woman who had just received some. To which a young man standing beside her replied, “No. Foreign medicine just works faster, so one needs to be careful in eating them.”

Complex and fluid ideas like this about the efficacy of medicines were sometimes linked to ideas about their origin. Nearly every health camp attendee I spoke with expressed a preference for being examined by *bideshi* doctors, as well as having more *biswās* (belief) in medicines given by them, as discussed in the last chapter. Recalling the Buddhist monk who suggested that *bideshi* medicine was filled with knowledge and money, or the many Humlis who wanted medicine only from the hands of a foreign medical volunteer, we see one view of efficacy rooted in the material inequalities that exist between Nepal and more “developed” (*wealthier*) places in terms of health care options, reputedly powerful healers, and other life possibilities more broadly (Harper 2003; Pigg 1992, 1996; Wendland 2010: 10). In some instances *bideshi* doctors trump local healers, and in other instances, this was not the case, as in the instances of camp attendees who seek out *dhāmi* to bless medicines. It is not my place—nor, perhaps, is it possible—to neatly discern which healing practices are used in what exact situation or for what purpose. As Gregory Maskiranec (1995: 73) has noted, the presence of multiple forms of healing practices is simply that—“not an accidental co-presence, not a system of balance, nor a system of contradiction, nor a system of paradox—simply, not a system.” However, one thing is clear: camp attendees seem to want and use a plurality of healing options, and access healers with the appropriate powers to control and direct the power of medicines, with hands and words, in the right context.

### **Health Camps and Everyday Strategies of Life**

In this section I propose that Humlis use health camps as sites to mitigate existing livelihood constraints and create new life possibilities. Taking a cue from Bonnin and Turner (2012), James Scott’s (1985) notion of forms of everyday resistance (1985) and Ben Kerkvliet’s (2009) ideas about everyday politics are useful here in considering the creative strategies of everyday life in

Humla, of which seeking medicine at health camps is just one. Most Nepalis who attend health camps do not neatly separate the experience of seeking medicines from their daily, protracted struggles to meet their needs in conditions that, as a result of histories of neglect, institutionalized underdevelopment, or war, do not promote health and wellbeing. As such, for many attendees, free medicine was an important reason for coming to the camp,<sup>109</sup> and they employed a variety of creative strategies to ensure that medicines would flow from the health camp, one way or another. However, medicines are obtained more readily and in greater quantities by those with better connections—more “source-force” (Justice 1986; Levitt 1999; Weiner 1989)—and, therefore, they are also objects that index inequalities.

While volunteering with a NGO in 2006, I watched as the tail end of the monsoon soaked large groups gathered outside the barred windows of a district hospital room, which was transformed into a makeshift dispensary for a nine-day general health camp. Camp attendees shoved in order to position themselves closer to the outstretched hands collecting prescription forms through the dispensary window. On more than one occasion, crowds that were crammed up close to examination room doors came barreling through: “I waited here all day yesterday and you ran out of my medicine,” shouted one man. “I’m not satisfied with this camp,” another man told me. “The doctor said there was nothing wrong with me. Look at how few pills (*chakki*) he gave me.”

Some camp attendees faked signatures, carefully practicing on scrap papers, and sat around in circles copying one another’s prescriptions and dosages. Others simply reached for loose tablets through the dispensary window, tried to reuse already-filled prescription tickets, or tickets from previous health camps. Many attendees came right to the dispensary without even going for an examination, as they saw others receiving chewable tablets, antibiotics and pain medications, varied ointments, vitamin suspensions, eye and ear drops. One elderly woman held up to the window a crumpled piece of newspaper, in which she had received 60 antacid tablets the day before: “Excuse me. I’ve eaten all my medicines and I don’t feel better.”

Those who were lucky enough to have *āphno mānchhe* and other “source-force” connections made use of these social networks and fictive kinship relations. Humlis who worked

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<sup>109</sup> A renowned Nepali physician who had conducted countless medical camps told me that people generally expressed this opinion to him: “We did camps in Nuwakot and for the ones who really can't afford it, we gave the medicine free also. But, others had to pay. And then people got annoyed. They said, ‘You know, if you're not giving away free medicines, why are we coming to the camp?’”

as camp volunteers—and who were selected by NGO and government hospital staff—often received identification badges that allowed them to access the insides of buildings and rooms not open to health camp attendees, and these badges were regularly shared amongst friends and family. Sometimes people sent their own children, or borrowed others, to demonstrate an urgent familial need to have a prescription filled quickly, or to receive more medications than what was prescribed or dispensed.

At one health camp I attended in 2004, one of the NGO's was simultaneously running their Little Doctors Program, which was a health promotion project offered to school children age eleven to eighteen. The students who participate learn about hygiene, sanitation, and basic first aid from a local Nepali health care worker, and are encouraged to spread the lessons they learn in their respective communities. At the end of the program, they are given certificates and a white doctor's coat with their name sewn on it, which they all wore to the health camps held in the Simikot hospital. The symbolic power of the white coat often manifested itself in the little doctors being given jobs by the NGO and hospital staff, such as directing people to the different OPDs and dispensary, or taking down patient information outside examination rooms. At this particular camp, the little doctors were assigned to the registration window, and had locked the door from the inside as they handed out to their friends and family waiting outside the window blank registration booklets, which served as both entrance tickets to the camp and were used to fill medicine prescriptions. Here we see the many ways that health camp attendees ensured that medicines flowed out of the dispensary in ways that would benefit the broad needs of a larger collective community.



**Figure 5.6** Large crowds wait outside a dispensary window at a nine-day medical camp in Humla, 2006.

The pursuit and procurement of medicines at health camps also reveal social inequalities. While volunteering myself at a health camp in 2004, I recall closing up the camp's dispensary each day as people would continue to bring prescription forms. One local Nepali volunteer mullered out loud, "*Kati tension bhayo!* (What tension!). All these people keep coming, it makes my head hurt. What should I take?" She sifted through the medicines left out on the counter, putting some in her pocket. Camp attendees waiting for prescriptions routinely saw GHWs and other volunteers sending family or friends to the front of long lines, or in this instance taking medications, which they considered free to them as participants in the camp. Sometimes they packed them up to take home for personal use, family members, or gifts to friends (cf. Subedi 2001). This confirmed for many what they already suspected to be true—that those with the connections to more easily access medicines do, in fact, take them behind closed doors.<sup>110</sup> In interviews, most camp attendees referred to this practice of *āphno mānchhe*. People's images of the kind of society in which they live are continuously reconfigured through these enduring, widely accepted social configurations of currying favor, adding to a growing awareness of a hierarchy of life possibilities. The health camp acts as a "social pharmacy" (Whyte et al. 2004: 14, 25) as much as it does a medical one, contributing to new and old kinds of social relationships that define opportunities for some while confining the life chances of others.

Many of the *bideshi* volunteer doctors were deeply troubled by Humli camp attendees' successful strategies to access as much medicine as possible, and several commented on the "outright depletion of stocks way faster than we expected," according to one UK physician. Livid about the locking of the doors by the Little Doctors (which was their own NGO-run program), the physician added that "these kinds of free medical supermarkets prop up an already smelly and corrupt system" while simultaneously perpetuating a "boomerang effect"—"We just throw [people] away and they keep coming back," he said. At the same health camp, enrollment books and registration stamps were stolen, blood samples went missing, and local officials harassed three German medical students volunteering to run the stores about the future destination of leftover medicines. "He wouldn't let us leave the room without giving him some of the leftover medications, like he was getting scary and demanding them there and then," one

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<sup>110</sup> Whyte et al. (2004: 22) has also observed that 'those big people' in Uganda have much easier access to the kinds of medicines that prolong lives, such as antiretroviral drugs (ARVs).

said. A volunteer Austrian pediatrician became so enraged that she demanded the camp be shut down, screaming that the “medical circus” must stop immediately. For the most part, *bideshi* medical volunteers at health camps were unable to see or keep in mind the larger context in which camp attendees sought to store up medicines, as they were overly focused on controlling the recorded numbers of medicines distributed for their files and donor reports.

In a few instances—both as a medical volunteer and while conducting research at other camps—I observed government health workers taking medicines during health camps to sell in privately owned stores. As told to me by one NGO-employed VHW,

Medicines that you have to buy and those that we don't have in store, the GHWs take. Some will be given to neighbors and friends...The people don't recognize which medicine is which, but [the GHWs] know. If this medicine is expensive, if it's not available in the hospital, if it's your expensive *bideshi* medicine, they take it. Perhaps some is also for personal use.

In many cases, health camp medicines were indeed used for other personal uses, in ways that often addressed non-medical needs. Two women I spoke with after a uterine prolapse camp told me they took their medicines back to a nearby pharmacy for money, which they then took to buy food for their families. Lasya, who I quote in the epigraph to this chapter, also recounted a time when health camp medicines were traded for sugar, which is exorbitantly expensive in Humla. Again recalling the family who required medicines to return safely to their village, the utility and meaning of medicines clearly extends to the meeting of much more urgent needs in such ‘out of the way places’ where life is difficult and uncertain. These must be seen as other deliberate—and therefore instructive—acts of ‘de-medicalization’—of finding ways to ensure that medicines are used to address other unmet basic needs. The implications of this should not be overlooked.

Aided by the growing number and kinds of medical camps, medicines are now more mobile throughout rural Nepal, further shaping the range of beliefs and practices that surround their pursuit and use. Just as their use- or exchange-value often fall outside of calculable economics or measurements of efficacy—there is no price on safe passage back to a village during time of war—the beliefs and practices often fall outside the concept of “rational drug use” as conceived in public health literature and evidence-based medicine (Nichter 2008a: 95). The creative strategies used to successfully obtain medicines at health camps, along with the plural ideas about health and healing used with these medicines, force a rethinking of the different

kinds of medical knowledges and basic needs brought to bare during these health care encounters. Though I have not exhausted the possibilities, exploring the social and political lives of medicines within the range of active responses to sickness and suffering adds to an expanded understanding of how medicines are meaningful. Much like the taking of medicines by government health workers—who were also frequently the target of Maoist extortion and threats—camp attendees’ strategies used to stock up on health camp medicines must be seen in the context of basic needs, redefined and unmet, in settings of privation and structural violence where an emergent nongovernmental government begins to consolidate access to and control over the basic material and non-material resources that promote and sustain health. In the next chapter, I turn to examine the social and political lives that surround food aid programs as they land in these settings so that we can continue to make sense of aid commodities and bare life, and to push further an examination of how the pursuit and attainment of food and medicine amidst the ephemeral worlds of episodic interventions and institutions condition the material and imaginative worlds of people in Humla.

## CHAPTER SIX

### **Unpacking Food Aid Rice: Changing Foodways, Hunger, and the Taste of Temporary Meals in Humla**

*Who is more uncivilised: those who can't grow their own food and who would starve if they didn't get their daily ration of subsidised air-freighted rice, or those who grow their own nutrition-rich millet and buckwheat and don't depend on the outside world? Instead of salt give us iodine, instead of rice give us irrigation, instead of sympathy give us hydropower... We won't starve just because you don't send us your rice.*

~ Jivan Bahadur Shahi, *Don't Kill the Karnali With Your Aid*

*There's no nutrition to this (food aid) rice, and it gives us diarrhea... But for the price it is good... And, what to do, we are poor people out here in this remote area, and we don't have enough food, so we have to think it's good (rāmro mānnai parchha)... But, for us hard working people, after two to three hours you're hungry again. It's not as good as our local food, like red rice, chino, and millet... If you pee twice, the (food aid) rice is gone already, but if you eat local food then hunger will stay far (stāniye khānna khāera bhok TāDai basne).*

~ Shiva Prasad Jaisi, farmer, southern Humla (author interview 2010)

#### **“Did You Eat Yet?” Talking about Food, Food Aid, and Hunger in Karnali**

In this chapter, I examine the creative ways that people in Humla seek out and use food aid rice, exploring these practices as partial livelihood strategies fashioned out of both necessity and choice. I also look at how seeking out and obtaining food aid informs how people experience and understand their own social and material worlds. Here, the active social and political lives of rice distributed through intermittent food aid programs becomes a key area of ethnographic investigation, and I highlight the strategies that Humli people employ to obtain this fairly new comestible as well as the often non-eating related ways food aid is used to meet other basic needs. In this way, I hope to draw out the similarities between food aid distribution events and health camps as models of care that tinker with life chances and aspirations, but do little to improve either. People walk great distances and stand in line, waiting for a helicopter to land with an aid commodity—in this case food aid—to which meaning, value, and use are both

intrinsic and affixed in a range of contexts. Food aid distribution events are temporally unpredictable and fleeting, but have a range of social and material traces and afterlives. I propose that intermittent food aid programs fill a need and provide a tenuous safety net for many households in Humla, but they also simultaneously (re)shape experiences of hunger and taste, and contribute to transformations in practices and values that surround growing, serving, and eating local foods. Humli people's ideas about themselves, their worlds both local and beyond, as well as their status in these worlds, are also remade in the experiences of seeking out and eating—and, most certainly, being interviewed about—food aid rice. As such, this is a chapter that deals with two kinds of hunger—hunger of the belly and of the spirit.

Drawing on observations, household survey data, and semi-structured interviews, in this chapter I move through a discussion of food and changing foodways in Humla, the cultural politics of food aid distribution and access, and then the idea of taste. In the rest of this section, I further contextualize my own interest in foodways in Humla, and discuss the major actors involved in delivering food aid to Humla, as well as representations of the hunger situation in the region. I then ground a discussion of the historical shifts in local foodways in the changing livelihood opportunities and practices in Humla before turning to examine food aid during the Maoist conflict. Following this, I discuss and analyze the narratives and stories shared by my research participants as they wait in line at food depots, and work for, unpack, cook, eat, trade, sell, re-distribute, and distill into alcohol food aid rice. In the last section, I discuss how the presence of food aid shapes ideas about “taste” in a broad sense—the taste of “marginal foods” (Finnis *et al.* 2012) compared to local foods, and the ‘flavor’ of eating food aid that is knowingly given away by wealthier countries where hunger is at least perceived to be less prominent.

In this chapter, I follow traditional theorists like Bourdieu (1984) as well as contemporary scholars such as Holtzman (2009) in exploring the social, material, and symbolic contours of food, taste, and eating in Humla, both in contemporary times and in their transformations over the recent past. If, as many scholars have rightly suggested, food aid is at best a problematic tool for addressing food insecurity in emergency or transitional contexts (Barrett and Maxwell 2005: 112; Harvey *et al.* 2010; Joergensen 2006), it is in many other ways and contexts a resource and a commodity that is imbued with historical, agricultural, social, cultural, and political economic significance outside those immediately associated with humanitarian relief.

### *Coming to Study Food and Food Aid*

My growing interest in food, food aid, and experiences of hunger in Humla came initially through conducting research on people's ideas and experiences surrounding short-term health camps, biomedicine, and patterns of healing. Humli people were eager to talk about these experiences, but they were also intertwined with other stories they wanted me to hear: stories about the unpredictability of harvests, new crop diseases and changing climate patterns; about privation and hunger during the Maoist conflict; and about their everyday livelihood struggles for subsistence, of which getting food aid was only one. During interviews both at and away from medical camps, I found that asking people about health led them consistently to speak about food. It became clear that it would be difficult to study one without studying the other.<sup>111</sup> In this way, my research began to tell me what it should be, and what was important for me to be learning (Chapman 2010: 56).

Since my first visit to Humla as a medical voluntourist in 2004, I have had the privilege of walking many miles throughout the district, learning about agriculture and sampling delicious Karnali foods: hardy mountain grains like barley, *chino* (a kind of proso millet) and *kāguno* (foxtail millet), and local rice varieties such as sweet red rice; steamed momos stuffed with cabbage, spinach and curried pumpkin; bitter and sweet buckwheat pancakes (*lagar*) and nutritious stinging nettle soups (*shishnu*); a variety of *dāl* and bean-based dishes (*simi*); foraged morel mushrooms; Humla's famous apples (*shyāu*) and walnuts (*okhar*), and tongue-to-roof-of-mouth-smacking *sāNdheko chuk* (the pulp of a large citrus fruit tossed with chili and local herbs); *puris* and pickle; roti made from maize covered in heaps of honey taken from pine bee boxes (bees and comb included!); freshly caught fish, spiced goat and yak meat paired with potent local grain alcohol called *raksi*. This tasty list goes on. I found the taking in of the land through consuming locally grown foods contributed to a more engaged, sensorial anthropology of food and sustenance (cf. Nichter 2008b), as well as an internalization and embodiment of

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<sup>111</sup> The other reason for studying food comes from my friend and colleague, Jeff Masse, a PhD student in the Department of Geography at the University of Washington, whose research examines how values produced through local histories of food and work mediate a "Food-for-Work" (FFW) road development project in Humla. Jeff encouraged me to study food and the politics of food aid along with him, and his love and deep knowledge of the subject has been a source of inspiration in thinking about and writing this chapter. Together with other friends from Humla, we are working on developing a promising project he thought up called *A Critical Karnali Cookbook*, which we envision to be a public-oriented intervention against popular representations of the Karnali as a chronically morbid and "backwards" place with bad food, perpetually in the midst or on the verge of a food crisis.

place. Through this process, I encountered pleasure, pride, humility, and history in learning about and observing the labor, care, and skills involved in cultivating Karnali's intricate foodways, eating the landscape as I go.



**Figure 6.1** Karnali foods (from top left to the right and down): local legumes; a local fish trap for the Karnali River; home brewed alcohol made from food aid rice; Humli walnuts; recently boiled honey; pickle fermenting in the sun; a homemade bee box; local beans (*simi*); corn being stored for the winter.

Once attuned to them, the sights, sounds, and smells of procuring and preparing foods are everywhere in Humla. They are in the light melodies sung to mother goats as they are separated from their young, gently bound, and milked in high mountain pastures, as well as in the distinct, cadenced grunts and chants used to drive plow-laden oxen forward in the fields. The rhythmic, echoing exchange of a methodically rotating circle of people pounding grains with wooden *gābri*—*thwap-thwap*, *thwap-thwap*—which will later be followed by the rain like patter of

granules falling on tarps spread across mud roofs, as the evening winds help winnow the chaff (Figure X). Strong whiffs of spices also float on these breezes, as spices such as *timur*, a Nepali relative of the Sichuan pepper, and *goDā morchha*, a delectable and piquant thyme-like herb, are dropped with a crackle into hot oil and vegetables. The rattle of these ingredients then being stirred in metal pots and, and the explosive *shhhhhheeee* of a pressure cooker over a fire, alert hungry bellies to the status of a meal.



**Figure 6.2** People pound millet with *gābri* (left); standing on rooftops, the evening winds help to separate chaff from pounded grain (right).

In Humla, people talk about food constantly. It is on their lips and on their minds, even when it is not always in their bellies. The centrality that food and the work surrounding food are accorded in daily conversation—as well as in folk songs, proverbs, and stories—reflects both its importance as the hard earned nutritional source of life, and its salient role in social, religious, political, and economic domains (Holtzman 2009: 9; Wilks 2012). Food and health also interact within the frameworks of local illness etiologies, as a grandmother warns her son not to feed his sick daughter spinach because it is considered a “cold” food—even when cooked—and will only worsen a cold. The gendered politics of food allocation can be seen when mothers gather and fill metal jugs at the water taps, discussing with one another concerns over their husbands and sons not eating enough; meanwhile their daughters—who have most likely eaten even less that day—overhear the conversation as they clean dishes. A family discusses the new kind of *rog* (Nepali: disease) affecting their crops as buckwheat pancakes are made early before sunrise, and plans for dinner are then made with all family members present to assign individual roles in helping to

prepare the meal, as they might not see each other again till dinner. A couple squabbles over how much millet was actually borrowed from their neighbor after last year's harvest, and how much to pay back this year. The going rate for chilies or cauliflower being sold by a mobile vendor is shared with a yell across a rooftop. In a monastery, a head monk tastes and comments upon the consistency of *chāng* ('rice beer') brewed for ritual offerings. And, as in other parts of the world where hunger is prominent, a simple greeting or exchange throughout any part of the day, even in passing, will typically include the question "*Khānna khānnu bho?*" (Did you eat [yet]?). As Dan Bahadur, a Thakuri farmer and father of six, told me early one morning during an interview before he set off for the fields,

You know, we Nepali people when we get up early in the morning we say, "*Namaste*, did you have tea? Did you eat yet?" It is something that is inherited, it speaks out early as the first words in the morning... We think about food all day because food is our life. And when we work in the fields, we sing about the food we will harvest... We people lack food out here in these remote areas, you know, all the people go hungry for some months during the year... So it's something that speaks about our situation, "Did you eat yet?"

His eyes cracked and he smiled, and then reached over to the pot of tea still warming on the stove to again fill our cups.

### ***Further Contextualizing Representations of Hunger and Food Aid in Humla***

Popular representations of Humla and of the Karnali in general characterize the region's food situation somewhat more simplistically; portraying it solely as a "backwards" place with bad or no food, its inhabitants perpetually in the midst or on the verge of a food crisis, and all desperately in need of food aid to survive. Each year newspapers show pictures of remote airstrips closed due to inclement weather, and headlines tell of food aid flight cancellations, warning of the annual disease epidemics and starvation that are sure to follow. Through these representations, Karnali has been locked into what we might call 'a suspended state of starvation.'



**Figure 6.3** Magazine and newspaper clippings regularly tell of food crises, famine, and hunger in Karnali. The top right clipping reads *Bhāt ko bhokmāri*, or “rice famine.”

This has been the case since the 1990s, when—following the first *Janā Āndolan*—the media acquired the freedom to report on issues that would have previously been suppressed by the government’s strict control over the press (Adhikari 2008), such as increasing food shortages, widespread hunger, and disease epidemics in remote areas. In this way, most Nepalis and onlookers of Nepal became familiar with these five far-flung districts of Karnali—Dolpa, Kolti, Mugu, Jumla, and Humla. In May of 1998, *The Kathmandu Post* reported on approximately 350 “famine” related deaths in and around Simikot, the district headquarters of Humla. One year later, headlines read, “Again, food shortages hit Humla,” “Humla residents starving,” and “Is the government doing enough to feed the masses?” (Adhikari and Bohle 2003). Newspapers also carried reports of the 400 or so people who died from influenza following the famine of 1998 (2055 v.s.), and the more than 1,000 Humlis that succumbed to a similar viral infection the following year. According to several doctors that visited the area at the time, the deaths were not the result of a sudden food shortage or famine, but rather stemmed from the conditions in which people were living. The medical personnel came back with reports of how the intense physical labor required for subsistence and nutritional deficiencies from food shortages accrued over a long period of time had reduced people’s ability to fight off disease. Referring to his time spent

in the region providing medical services during the 1999 epidemic, Kedar Nath Sharma, a senior medical officer, said that ‘medicine would not have solved the problem because it does not work for hungry people’ (Adhikari 2008: 2, 78).

Though the increase in reporting about hunger and disease epidemics only began in the 1990s, the government has been delivering subsidized foodgrains—primarily coarse rice—to the Karnali since 1972 through the Nepal Food Corporation (NFC), a state run welfare agency created to address the growing food shortages in remote areas.<sup>112</sup> In 1967/68, Jumla had recorded a grain surplus of 4,168 metric tons (MTs), however the district reported a deficit of more than 15,300 MTs just three years later in 1970/71. This deficit grew to 17,400 MTs in 1975/76, which prompted the NFC to begin to focus more heavily on the region for food assistance. The recorded deficit in Humla remained comparatively small (between 1,000–2,000 MTs) until the mid 1990s, when the deficit rose to 6,300 MTs. In 2001, this deficit increased to reach close to 7,000, but as of 2009 had reportedly dropped to 5,700 MTs (Seddon and Adhikari 2003). As I’ve already discussed, statistical sampling methods in Nepal are inherently flawed (see chapter two, footnote 69) The likely inaccuracy of these figures notwithstanding, over time the intermittent flying in of food aid to mitigate food shortages in Karnali has become a defining feature of the region (Adhikari 2008; Lama 2002).

Initially the government sourced NFC rice from Nepali farmers in the Tarai who produced surplus grain, which was then redistributed at subsidized rates to districts with “food deficits.”<sup>113</sup> The goals of the NFC were, *inter alia*, to stabilize prices, purchase foodgrains while securing the interest of farmers, and ultimately mitigate food shortages. This idea of mitigation—as opposed to elimination—is important to remember. However, throughout its existence, the NFC has struggled to balance its humanitarian efforts with its fiscal solvency. This balance proved increasingly difficult after Nepal adopted IMF and WB-imposed Structural Adjustment Programs in the late 1980s. Overall, SAPs curtailed public expenditures designated for national enterprises, which, for the NFC, meant an overall reduction in food relief operations, a switch to

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<sup>112</sup> See Tambahangfe (2010) for an excellent discussion of the emergence of NFC in historical perspective, and the effects of neo-liberal reform on the policies and practices of the welfare agency.

<sup>113</sup> The concept of “food deficit” is problematic for several reasons. As Orans pointed out long ago (1966: 25, cited in Fisher 1987: 46), levels of subsistence are inextricably cultural, which is why economic models of subsistence based on utilitarian or “rational” modes of production or procurement fall short of capturing the whole picture. Nor do strictly quantitative analyses of food security reflect the socio-cultural reasons why people cultivate and prefer certain foods to others. Lastly, they largely miss elucidating the lived and embodied experience of hunger.

a regional “targeting” system, and a greater reliance on open markets for grain procurement. All of these changes would prove even more expensive and inefficient in the long run (Adhikari 2008; Pyakuryal 2009; Tumbahangfe 2010).

According to reports from the NFC sales department, in the twenty years from 1985–2005, the agency provided roughly 50,000 metric tons of food aid to Karnali’s five districts, with the number of MTs increasing year by year (Adhikari 2008: 178) until 2005/06, when the amount decreased. In the 2009/10 economic year, the NFC spent Nepali Rupees (NPRs) 61 *karoD* [~USD\$ 6.9 million] on food aid rice, 70% of which was spent on transporting 67, 496 quintals (~3,300 MTs) of food aid rice to Karnali (Boharā 2067 *v.s.*). This process for allocating NFC rice quotas to remote districts is often encumbered with national and local politics and economics (cf. Wallace 1987; Shahi 2005). For example, it is often reported that food depots are shut not only in places where transportation costs are high, but also in districts with political leaders that oppose the policies of ruling parties (Adhikari 2008: 189). It is, thus, commonly accepted that the NFC is beset by inefficiencies, leakages, and elite capture of the massive amounts of foodgrains sent to Karnali (Pyakuryal *et al.* 2009; Tumbahangfe 2010; Whelpton 2005). Seddon and Adhikari (2003) have suggested that—despite these astounding figures—as much as 60% of all the food assistance supplied to Karnali by the NFC ends up feeding government employees. For one, food aid is used as an incentive to encourage civic employees such as teachers, health care workers, and police and army personnel to stay in remote districts—which are highly undesirable posts, especially for educated Nepalis used to the amenities of life in Kathmandu. Food aid is also used as a political tool to garner votes and curry favor, and is thus inextricably connected with local, deeply entrenched socio-cultural configurations of deference and obeisance, such as *āphno mānchhe*, *chakari*, and ‘source-force’ (discussed in chapter two). Further, in a strange regressive logic, Nepalis working for NGOs in Humla are apportioned more rice at a cheaper price at NFC depots than the 5kg per person per family allotment that households without these affiliations are entitled to when they present their ration cards at food depots (Figure 6.4). I discuss the local politics of seeking and receiving food aid at NFC depots further in this chapter.



**Figure 6.4** A Nepal Food Corporation ration card

In addition to the NFC, the United Nations World Food Programme (WFP) is the other major organization involved in providing food aid to the Karnali. WFP—known colloquially as *bishwā khāddhya* (Nepali: ‘world food’)—is the world’s largest humanitarian agency involved in the global neoliberal governance of food security.<sup>114</sup> WFP has been working in Nepal since 1967 (UNAN 1996: 74),<sup>115</sup> and they have become the major contributor of food aid to Karnali. In 2009, WFP airlifted 114,380 quintals of rice to the region (Boharā 2067 v.s.: 20), nearly double the amount of rice provided by the NFC. In Humla, WFP partners with other smaller NGOs based in the district, which facilitate the administration of a variety of programs. These include humanitarian relief operations, or emergency food aid, such as the rice given during the Maoist conflict, and project food aid, such as food/cash for assets (F/CFA) and food-for-work (FFW) projects (Barrett and Maxwell 2005). This partnering with NGOs reflects WFPs broader policy shift towards increasing the utilization of NGOs for local food aid distribution. This is evidenced by the volume of food aid they handle; for example, in 2000 NGOs served as the conduits for 28% of all global food aid flow, a historic high (*Ibid*, 15).

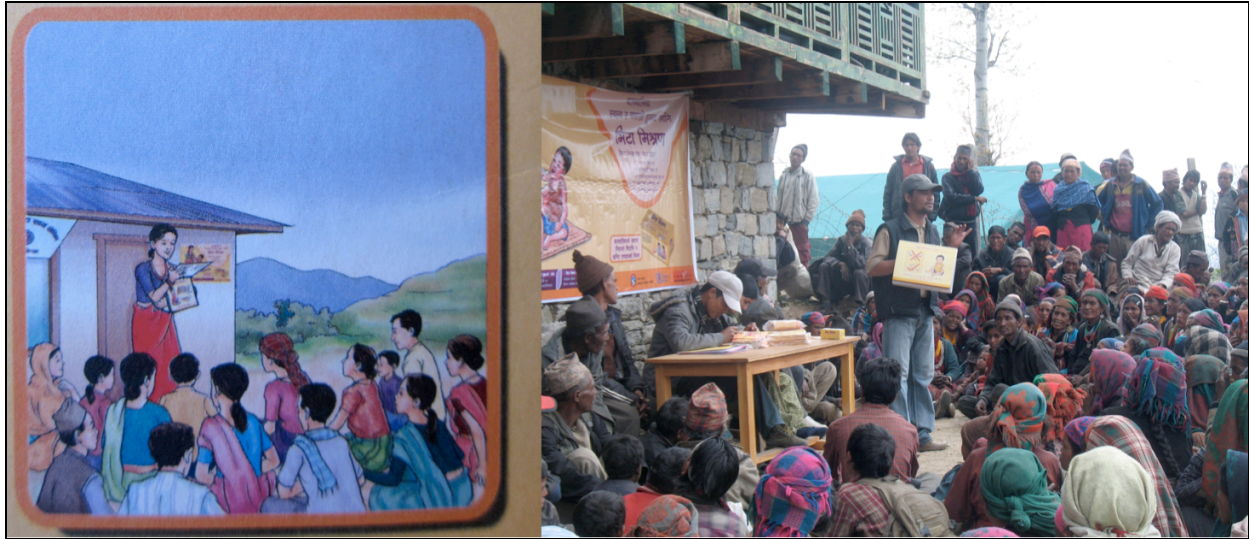
<sup>114</sup> In 2003, WFP had an operating budget of 3.3 billion, ten times that of the FAO (Mousseau 2005: 21).

<sup>115</sup> See Shaw (2001, 2011) for excellent discussions of the WFP in historical context.



**Figure 6.5** Humilis ascend a hill to meet WFP helicopters delivering food aid (WFP 2010).

Other WFP programs include partnering with local NGOs to distribute free packets of micronutrient powder—called *bhita mishraN*, or ‘vitamin mixture’—to those parents who also participate in the cash-for-assets programs. They are required to register themselves and the number of children 6-months to 5-years-old (59 months) as part of a strategy to reduce under-five and infant mortality rates. Using a triangle flip-board pamphlet, a Nepali NGO worker instructs a crowd of (mostly) mothers to sprinkle some of the mixture on top of the food they feed their children every day. To be sure, vitamin supplementation is an important intervention. However, it is a dangerously late sign of crisis when something in a sachet is required to save children from dying of chronic under-nutrition. Moreover, the practice of only providing it to those who participate in other WFP programs perhaps removes the voluntary nature of those involved, while also precluding those who might not have time to participate in the CFA programs from having access to these vitamins, and therefore may be missing a large swathe of the population facing the greatest vulnerability.



**Figure 6.6** A packet of *bhita mishraN* (left) depicts a WFP-affiliated NGO worker delivering the nutritional information and steps for preparing and feeding the multivitamin mixture; (right) The program being delivered in Simikot.

WFP also distributes food aid through jointly sponsored health camps in coordination with development organizations, Nepal’s Ministry of Health and Population (MoHP), and other branches of the UN, such as the UN Family Planning Association (UNFPA). It could be argued that providing food at health camps is more of a substantive intervention in wellbeing than simply providing analgesics and antacids. However, a former Nepali WFP employee I met in Simikot expressed a different opinion. Saroj was thirty years old and used to work in Mugu with WFP up until one year ago when he joined another large INGO in Nepal because he “couldn’t just toss out crumbs of food anymore.” He agreed to answer a few of my questions in a non-recorded interview only after he made me ‘promise on my next week’s worth of meals’ that I wouldn’t use his name in my dissertation. Commenting on the joint mobile reproductive health camps and food aid distribution programs, he said: “Of course they will come if you give them food. Then you can convince them for the sterilization.”



**Figure 6.7** MoHP and UN jointly sponsored health camp and food aid event. Source: public website; photo credit, James Giambrone, WFP.<sup>116</sup>

In 2000, WFP partnered with several NGOs in Humla to help operate a Food-For-Work scheme to assist with the completion of a 62km road from Simikot to the border of Tibet. The completion of this road would in theory allow Humlis to travel in one day what was normally a four day walk (for *bideshi* travelers, we could say five days). Many Humlis told me and my research assistants about the benefits (*phāida*) that the road would bring, such as being able to sell vegetables and fruits along the road to travelers and having much easier access to markets in Tibet to buy goods. Still others said that the road would bring disadvantages (*beiphāida*) and other problems, such as an increase in illegal timber sales across the border with Tibet. Several Humlis said the road would destroy their fields and bring pollution, while others talked about how it would bring new forms of inequality between those who could and could not afford to build business along the new road, and even bring people from Kathmandu to invest in the area, monopolizing local business opportunity. It strikes me that these concerns are warranted, as there is little evidence that household income or economic security improves for communities when roads are built while other basic rights and needs remain unaddressed (Blakie, Cameron, and Seddon 2001 [1980], 2002a [1979], 2002b). In a grimmer scenario, the road would bring an increase in trekking companies, resource extraction and other roadside business opportunities,

<sup>116</sup> Link to photo: <http://www.wfp.org/photos/emergency-operation-health-camp-mobile-health-camp-bajura-7>.

which would accumulate labor in Simikot, drain human input from agricultural systems, and turn the already less-well-off in Humla into a new proletariat for market relations and modes of production that would only diminish their health and life chances.

Construction for the road began in 1992, and to date Humla remains Nepal's only district without a motorable road connecting it with the rest of the country. Tibetan speaking Buddhist villages situated north of Simikot who participate in these FFW programs rotate work schedules throughout the year, and are often responsible for segments of the road nearest to them. Other Thakuri and Chhetri villagers often walk for days from southern Humla to work on the portions of the road contracted out to NGOs working in the district, of which there are several, all ensconced in their own set of local politics. As such, certain parts of the road are complete and drivable—should a car be airlifted directly onto it—while other sections erode right off the gravely slopes with every monsoon season, only to have workers repair them the following spring. Over time, it has become clear to most Humlis that this is not a road-building project, but rather a rice distribution project. “If we need a road, why won't they just build a road” (*BāTo chāyo kinā bāTo nabanāune ta?*), an elderly man puzzled aloud to me and my Nepali traveling companions at a seasonal teashop set up just beneath the Nara La pass that leads to Nepal's furthest northwest border with Tibet. I had heard this sentiment from many people in Humla, who were beginning to doubt that the road would ever be finished. This man had worked on the road last year with his son, and he too was unconvinced. “No, I don't think it will be finished. The mountain rock is too loose here...But, look, if you laid down and paved the bags of rice that they fly up here each year, you could build a road to India and back.” Now 20 years after the initiation of the project, with less than a third of the road completed, I take no pleasure in considering if there may be some truth to that. Let us see the underlying critique of this form of “joking”—something regularly done in Humla in a sometimes rote *commedia dell'arte* fashion—as a trenchant and scathing critique of this new form of peonage, and of failed humanitarian efforts and development promises. Though never stated in these terms, Humli people are aware that the FFW road scheme extracts their surplus labor with meager recompense, and promises little in the future.

Meanwhile, the trend of representing people in Karnali as perpetually starving, only to be saved by this external food aid assistance continues. These representations often combine aggregate or likely imprecise statistics with enduring ideas of hidden mountain landscapes and

peoples to further a seemingly unassailable moral logic for continued intervention. A recent BBC (2011) article entitled “Malnutrition crisis looms for remote Himalayan villages” provides a case in point, as the author draws on familiar tropes to contrast the beauty of Karnali with the poverty and privation of those who live there:

Prakash Shahi, nine, lives in a simple mud-walled home in Joripani. His father, Suresh, showed me his store of food—a solitary bag of rice donated by an aid agency...“Children are not healthy in this area,” he says. “They can’t survive without food.”

...From far away, these craggy mountains dotted with white washed houses look idyllic—the perfect vision of a Himalayan Shangri-La. But up close, this village is dirty, fly-infested and poor. The rate of chronic malnutrition is 70%. You can see it in the children who are fair-haired and listless because of vitamin deficiencies. The average life expectancy here is only 47.

For the past decade, international agencies like the UN World Food Programme (WFP) have been flying food into this region to prevent starvation...Prem Bahadur Malla, a farmer, says the village would not survive without food aid.

To be sure, hunger is a fact of daily life in Karnali, with devastating effects on the health, wellbeing, and hope of communities who live there. In my conversations with Humlis, people spoke regularly of *bhok* (Nepali: hunger) and *bhokmāri* (Nepali: famine [lit., death from hunger]), internalizing these reports and representations, embodying them. People discussed coping strategies to deal with constraints on eating, such as selling animals or other belongings for money to buy food from neighbors. Cash debt was common among households, and many poorer families engaged in work for other families in exchange for grain, a system known as *besa hālnu*. Some said they tried not to think about being hungry, though their bellies told them of it consistently. Often, coping with hunger entailed little more than reducing the number or size of meals per day, and going to bed hungry was a common theme discussed in interviews. “*Bihāna ali khāne belukā khāne, kahile nāstā, ahh, kahāN tin chhāk hunchha!*” Dalu Rokaya told me when I asked her if she ate three times a day, (We eat in the morning and in the evening, sometimes a small snack in the afternoon, *ahh*, what three meals!). “Look at our children,” Dhana Kumari Shahi, a twenty three year old mother of four, told me during an interview in her home, gesturing to her kids who sat clutching their freshly-licked-clean bowls. “It makes me so sad...What to do? I feel like I am a bad mother...And to have to see them so skinny like this, this

kind of hunger without end (*yetai pātlo, yasto kahilesamma bhok*). What to do? We are hungry. We work so we can eat, but it is not enough.” Dhana Kumari’s comments evoke the lived experience of hunger in Humla, which is constant and chronic, not reducible to caloric intake or deficiencies, and the pain of it shared beyond personal bellies. Her words bespeak a hunger “of those who eat every day but of insufficient quantity, or of an inferior quality, or an impoverished variety, which leaves them dissatisfied and hungry” (Scheper-Hughes 1992: 137). Sadly, her words are also those of so many others who struggle everyday with obtaining enough food.

The visible signs of chronic undernourishment are ubiquitous in Humla, though the extent of this deprivation varies throughout districts and throughout VDCs within districts, along ethnic lines (typically, food insecurity is more severe among Hindu communities than the Tibetan speaking Buddhist communities), and within households. Aggregate estimates—though likely imprecise—of under-five stunting in the district are as high as 90%, and wasting around 70% (UNDP 2004, cited in Adhikari 2008: 11). Nevertheless, the swollen, protruding bellies—known as kwashiorkor—are unmistakable signs of how little protein children consume. The emaciated bodies of other infants and children indicate marasmus, the result of missing calories and nutrients. Many adults—women in particular—and the elderly are similarly devoid of body fat reserves. Humla ranks at the bottom of all 75 districts in Nepal in terms of per capita overall food production (ICIMOD 2003, cited in Adhikari 2008: 10), as well as last in per capita cereal production (Shively *et al.* 2011).<sup>117</sup> Among the households I surveyed in Humla during fieldwork (n=124), approximately seventy five percent reported being unable to produce enough food from their own fields to last throughout the year, and I suspect the number is higher for all of Humla. Just over sixty five percent produced enough food for six months, while close to thirty percent enough for only three months. Many households were in debt as a result of food-related expenses, or had sold animals to buy food from a neighbor.

However, one-dimensional representations of vulnerability and food insecurity like those in the BBC article and in NGO reports are in many ways divorced from the realities that Humli people face in their everyday experiences and struggles for wellbeing. They tend to perpetuate uncritical narratives of endemic hunger and poor health, rather than helping to illuminate the historical and structural reasons why so many people experience hunger and food shortages as

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<sup>117</sup> The FAO and WFP (2007) consider the minimum requirement for sufficient per capita cereal production to be 150 kg/person.

one consequence of rapidly changing foodways. These factors include unpredictable and changing geo-climatic factors, the effects of emerging local and regional cash economies on trade-based and agro-pastoral livelihoods, and legacies of internal exploitation, institutionalized neglect and underdevelopment, discussed in chapter two. Much like the health camp report that argued that Humlis would simply die if health camps were to cease coming to the area, food aid programs are cast in a similar light. Such portrayals continue to characterize Humlis and other *Karnalivasi* as food aid dependent, even when food aid does not seem to account for very much of a household's food consumption; in Humla (2003/04), for example, estimates were as low as 17% (Adhikari 2008: 181). These representations also overlook the range of other foods that are eaten and enjoyed in Karnali, and ignore the multiple and often inconsistent reasons people seek out food aid in different contexts, how they talk about this rice, and what they do with it once it's obtained.



**Figure 6.8** Not to be sold or exchanged” – USAID and WFP food aid arrive on a helicopter.

In contemporary Karnali, food aid rice has acquired a whole new set of complex social, political economic, and agro-pastoral relations, meanings, and uses, all of which I do not intend to detail or analyze here. Food aid is a commodity in the simplest sense because it is purchased, or

exchanged for human labor. Yet, like medicines obtained at health camps, food aid rice has value outside of its involvement in production circuits of (sometimes) involuntary commodity chains of surplus and demand. Of course, food aid is consumed, but it does not always satisfy, for gastronomical reasons as well as those related to broader interpretations about the origins of the food. Food aid is also given as a gift, and divvied up according to village allocation systems. It is made into alcohol for sale in teashops, and brewed for ritual purpose. Getting food aid—especially through *āphno mānchhe*—can be a symbol of status or of having ‘source force,’ but asking for it is also a visible and performed sign of penury.

Further, for Humlis, obtaining food aid is often just the beginning of its active social life, and it will invariably enter other political-economic, religious, and agro-pastoral spheres of life. What people do with food aid after they obtain it varies; it may be eaten or it might be inedible, soiled and unappealing after months or years of travel and storage. And, food aid rice may ultimately help meet basic needs in other communal, lucrative, or more satisfying way. These exchanges and uses—both economic and social—are entrenched in different regimes of value (Appadurai 1986); that is, the meaning and worth of rice is often rendered visible through its movements and uses outside common circuits of value. Food aid, then, is useful and of value because of its ability to move both into and out of commodity state (Kopytoff 1988), and because its acquisition allows Humli people to meet a range of basic needs. It is a commodity—especially when in motion—with a complicated and meaning-full biography, which I attempt to detail here.

I begin the next section by expanding upon chapter two’s discussion of changing agro-pastoral practices and foodways in Humla, focusing on the effects that the influx of cheap, iodized salt from India had on local livelihood practices, the regional economy, and social relationships that previously helped stave off hunger and hardship. I then discuss food aid and hunger during the Maoist conflict before turning to discuss food aid distribution events in Humla. At these fleeting events, much like health camps, villagers often walk great distances, wait on long lines, access social and political connections, and employ other creative strategies in hopes of meeting basic needs. I focus specifically on food aid distribution at the Nepal Food Corporation’s (NFC) depots operated throughout the district, and some on WFP projects coordinated by NGOs, which were largely centered on protracted relief operations both during and following the People’s War, and food-for-work (FFW) and food/cash-for-assets (F/CFA) projects currently underway in Humla. Paying attention to how people get this food aid, what

they think about it, and what they do with it expands our understanding of the socio-cultural and agricultural implications of this model of short-term care, as it has become clear that food aid is not being used or received—in both senses of the word—in the ways its purveyors always intend. As Appadurai (1988: 26) notes, “the diversion of commodities from specified paths is always a sign of creativity or crisis.” In the case of food aid seeking and use in Humla, it seems to be both. For Humlis to confront a growing crisis of livelihood, obtaining food aid necessarily requires a great deal of creativity.

### **From Grain Trade to Food Aid: Changing Livelihoods, Changing Foodways**

*There is no place in the modern world for journeys whose length is measured in pipefuls of tobacco. Time does become money and, unfortunately, a lack of money can cause a lack of time. But time had been a buffer and friend here in Karnali Zone—life had been difficult but tolerable so long as the richness of options for trade and movement could be substituted for the poverty of immediate resources.*

~ Barry Bishop, *Karnali Under Stress*, 1990

*Before, the food from here used to go to Tibet. Now, if the [food aid] rice stops coming for just one week, people will die of hunger.*

~ Ganga Prasad Bhatta, chairman of the Humla Teachers Union

In the late 1960s, the Himalayan scholar Christoph von Fürer-Haimendorf travelled through Humla to study the interlocking systems of agro-pastoralism, migration, and trade that brought Hindus and Buddhists into close contact in the Karnali and formed the basis for regional livelihoods. Though other routes throughout Karnali held significance in the ancient salt-grain-rice circuits, the trail that wound directly through Humla following the Karnali River was the most heavily traversed and saw the greatest amount of trade. It also linked traders to the ancient Tibetan trading market of Taklakot (Purang), whose history as a central destination for this extended trade network can be traced back many centuries to the days of the Malla Dynasty (12<sup>th</sup>–18<sup>th</sup> C.E).

These trading caravans are also deeply linked to mythology and folk tales, in which the movement of gods, people, and animals coincide. Lord Shiva—who resides on Mt. Kailash<sup>118</sup>—and his wife the goddess Durga (Parvati) are said to move south towards the plains during the winter; with their return to the Himalayas come spring and its bounty. Wild ducks, black-necked cranes, and other birds fill the Karnali sky during these months as they return from feeding on Indian Ocean salt. They head north to the areas in and around holy Lake Manasarovar in Tibet, where they again find the salt they need. Karnali herders and traders relate their own migratory patterns to those of the birds, who provide them with seasonal guidance and inspiration to endure the long and difficult journey from the Tarai to Tibet in search of food and livelihood (Lama 2002: 37).

Until recent decades the livelihoods of both Tibetan speaking Buddhist (Lama) and Chhetri and Thakuri Hindu communities<sup>119</sup> in Humla were, in one way or another, dependent on these complex patterns of movement of people, animals, and goods.<sup>120</sup> In my conversations with Humlis in both Tibetan speaking and Hindu communities, people would regularly harken back to days when food and other goods were difficult to acquire through these movements, but seemingly more plentiful than in current times. Elders spoke of the reasons for these changes in terms of both the external factors that prompted them, and the ways they changed people's attitudes and practices in the community.

My friend and research assistant, Subash, and I sat with eighty-seven year old Jeevan Prasad Rokaya one chilly October morning for an interview after a breakfast of lightly sugared tea and fire-roasted corn on the cob. We asked him how life had changed since he was young, and exhaling a huge amount of smoke from a cigarette through his mouth and nostrils, he began, “*Mānchhe alchhi bhaechha*” – “People have become lazy.” We sat on his roof beside soybeans and beaten grain laid out to dry on tarps in the sun, which inched over the high hills and began to warm us. Subash, was an expert at the art of interviews, and he encouraged Jeevan Prasad to explain a bit more. As he spoke, his eyes remained fixed on his hands, periodically picking up fistfuls of light brown millet, and then letting the grains sift through his fist into his cupped palm

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<sup>118</sup> Mt. Kailash is sacred to Buddhists and Hindus alike, and located just across Humla's border with Tibet between the Gurla Mandata [Memo Nangni in Tibetan] to the southeast and Kunlung to the northwest.

<sup>119</sup> Von Fürer-Haimendorf (1975: 275) writes that some people say the Thakuris only became involved in the trade in recent generations.

<sup>120</sup> Jeff Masse described to me seeing large herds of sheep and goats headed off for the salt trade from Nyimba valley as recently as 1997. See von Fürer-Haimendorf (1975, 1978: 351-357) and Ross (1982) for detailed descriptions and discussions of these barter-trade routes.

beneath before spreading his fingers to let the granules again reach the tarp:

Things have changed a lot since way before...People used to walk for days to Taklakot [Tibetan market], sleeping in caves or on the side of the path with the animals for warmth...I walked with my father the first time...We would sell grains in Taklakot and bring back salt and other goods, and there was plenty of food because in other months we worked hard in the fields...People then were more friendly (*milansar*) because you had to depend on one another, and we worked so hard...Nowadays, people are greedy (*lobhi*).

Jeevan Prasad began to look a bit more at me and Subash, and he became much more animated, his tone inflected with an energy bordering on anger. He twisted his open-fingered hands by the wrist at moments for emphasis, and slapped one hand in another before bringing it back up, pointing at the sky with the index finger. Sometimes he picked up handfuls of grain and lightly tossed them back in the pile, scattering them back to the ages of which he spoke:

Yes, of course there was hunger, but you could go to your neighbor and they would give you some wheat and some beans, because they worked hard too...Now for a meal, even your neighbors want money! People have become greedy (*lobhi*)...Back then, having 20 rupees was like having 20,000 rupees. These days goods are so expensive! Look, 20 rupees for an egg in this village! Things are very different now...People drink alcohol and sit and play cards, place bets...Our children don't want to farm...they want to eat \*biscuits\* [cookies] and chow-chow [instant noodles], and they have no interest in our traditions...Nowadays we don't walk to Taklakot, we walk to Simikot to buy salt and rice brought by planes. That is what you asked about.

Subash and I had indeed asked Jeevan Prasad—along with hundreds of other people in Humla—what he thought about food aid rice, both from the NFC (known as *khāddhya*) and WFP (*bishwa khāddhya*). “The rice is fine, the taste is also fine,” he said, which many people also told us, though often with much ambiguity, which I discuss below. “But, it ruins people's mouth and thinking,” he added (*chāmal le mānchhe ko mukh ra sochāi bigrarne*). “People leave their own fields...What else is there, but getting up each day and working for food?” He then inserted a Nepali proverb to emphasize his sentiment: “*Kisānko hātmā bhāt alchhiko bhāgmā āNsu*” – “In the farmer's hand rice, in the lazy person's part [portion] only tears.”

Of course, Humlis are anything but lazy; up early in the morning to tend hearth fires, graze animals, bring water, and propitiate deities with incenses and offerings; but still laboring well

into the moonlight, thrashing grains or rolling them over and over with ones feet. Of course, the labor and care that surrounds food continues. Yet, Jeevan Prasad's comments also point to important changes in Humla's foodways and diets that have resulted from the loss of agropastoral and trade-based livelihood practices. This resonates with the ideas of many in Humla, particularly elders who could recall days before food aid rice and packaged salt were available in the district headquarters. As Linda Stone (1978: 47) has noted, "any discussion with elders about the old days will immediately bring forth references to food as a criterion for the 'good life.'" Kunsang Lama, a sixty-one year old Tibetan teashop owner in the northern part of Humla, was no exception:

Look, I remember before. Compared to these days, before a long time back was very good. Before there was less food, but people were not hungry like today. Life was good then. Now life has become difficult...Now people know that food aid rice (*khāddhya chāmal*) is brought by helicopters so they think, 'Oho! We are poor now, here there is a famine.' So now people say more that 'We are hungry,' and they don't eat our own local foods. They don't grow local foods.

"*Bhātai bhāt!*" Haris Chandra Shahi, an elderly villager from Simikot, said, "Rice and just rice! That is the problem...It is not like before, that is what people like to eat in these times...We used to eat so many different kinds of food, like wheat, *chino*, red rice and amaranth. But people do not want these foods anymore, so we will continue to eat rice now." I had always wondered why more amaranth wasn't grown, as its grains and leaves are hardy and nutritious, and, according to Subash, the plant itself required less tending to than other grains like wheat, barley, and millet. "You know, people here don't eat it because they only want white rice," he said. "Those are poor people foods. People think white rice is better, and modern people eat white rice. That is the thinking these days, that you have to eat white rice." Here—and as I will show in the rest of this chapter—food and changing ideas about eating become a particularly rich area for constructing memories (Hotlzman 2009; Stone 1978; Sutton 2001), as well as imagining futures.

In addition, Humli people speak of the loss of enduring social relationships and notions of village communalism, to which Jeevan Prasad's comments also elude. "People nowadays have become *lhobi* (greedy)," he said, which was a common theme expressed in interviews. "Before, people were friendly. In this day and age people are no good," Dhir Bahadur told me (*Ahile jamunā mā mānchhe niko chhaina*). "People only think about money," Jangmu Lama told me:

Everybody wants to be rich now, people are more clever with planning for their future...They don't work together. Two years ago there was a fire in our house and we asked neighbors to help us rebuild...They asked for 200 rupees for the day. Before people didn't ask for money.

James Fisher (1987: 175-182) observed similar changes in “village ethos” among the Tarangpur in Karnali’s Dolpa district as a declining salt trade was replaced by new and shifting exchanges involving the introduction of cash into these circuits of manufactured commodities and animals. He describes a lessening of an “ideology of equality and reciprocity,” and a breakdown of “village solidarity” that characterized inter-village relations. He is, however, careful not to romanticize the idea of complete egalitarianism and notes that, despite this belief system, there remain clear differences in status, wealth, and access to resources. As Fisher writes, “The tension between ideology and behavior is seen in the new pursuit of wealth, power, and prestige,” which results from the introduction of cash into a formerly agro-pastoral and trade based economy (*Ibid*). Previously, mutual exchanges of labor and gifts in grain and sometimes cash to those who suffered crop failure or other hardship, while promoting a sense of indebtedness and gratitude, would not typically be repaid. If reciprocity occurred, it was not considered repayment, per se, but rather a gesture that would have been made regardless.

In Karnali, there were several such systems of cooperation and mutual aid, such as *dharma bhakari*, where all who were able to contribute would put aside a certain amount of grain for a reserve store for times of misfortune (Adhikari 2008: 74-5). Short- and long-term systems of ‘food credit’ were also practiced throughout Karnali (Bishop 1990: 316). In contemporary Humla, the cash economy has become a new, indispensable feature of procuring food. Food is often purchased from neighbors when one’s own crops are not sufficient, are eaten by a wild animal, or are the victim of a “disease” (*rog*). Nowadays, all villagers know the approximate cost per unit measure of local foods, with slight variation based on inter-personal village ties: one *pāthi* of local beans (*simi*) generally costs 60 NPRs, and chilies go for 100 NPRs; one *khāl* (approximately 20 kg) of buckwheat costs 400 NPRs, corn is 700 per *khāl*, millet is bought at NPRs 800 per *khāl*; wheat is 1200 NPRs and red rice is 1300 NPRs per *khāl* (See Bishop 1990: 375 for local measurements and conversions).<sup>121</sup>

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<sup>121</sup> Humlis are learning to apply prices to their foods and their time through other means, as well. For example, the assemblage of organizations working on the development of a Great Himalayan Trail—the UN WTO, SNV, and

However, the switch from grain trade to food aid did not simply entail the substitution of an agro-pastoral and trade-based life style with an economic one; just as the salt-grain-rice circuits of Karnali were never based solely on economic rationales. Caravan routes and movements were steeped in and cultivated longstanding social relationships and political institutions that linked friends and fictive kin over great distances. As Scott (1998: 252) notes, the loss of social ties is almost as productive of famine as crop failures: “Communal ties, relations with kin and affines, networks of reciprocity and cooperation, local charity and dependence had been the principal means by which villagers had managed to survive periods of food shortages in the past.” This most certainly applied to Humla as the regional economy underwent dramatic changes.

Jeevan Prasad was one of several elders that told us about how they recall being a child when Humli farmers from the south brought red rice, barley and other grains from the hills, which were highly desired by Tibetans. Traders from Taklakot would also come into Humla as far as the villages of Yalbang in the current day VDC of Muchu to barter for these grains, as well as bitter buckwheat (*tite phāpar*) and *bhuse jāu* (thick-husked oats) that came from Rodikot in southern Humla. There would be three-week *hāt bazars*, which took place on a rotational basis in villages near the Tibetan border in Humla, like Chala and Yalbang; and the following year would take place in Tibet. Lama (2002: 46) notes that Tibetans would willingly pay whatever rate of exchange for these grains, however, rates more likely depended on seasonal variation of yields and other personal ties (Ross 1982: 44). Traders established fictive kinship relations—called *mit* and *ista*<sup>122</sup>—that allowed for the solidification of preferential trading partners from Tibet and Nepal. This bond was often consecrated with the ritual slaughtering of a goat or sheep, with the exchange of other gifts, and sometimes entailed taking a vow in the name of the holy Mt. Kailās and Lake Manasarovar. Before a plate of rice by the banks of the lake, they would bind their relationship “and secure their business commodities [while] also wishing the friendship be as

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other local Nepali NGOs—have been organizing training sessions for teashop owners along the Karnali River trail that lead to the border of Tibet. The training booklet, called *Daksha Cook* (Capable Cook) instructs the reader how to affix prices to their labor and foodstuffs in order to set a menu for trekkers. With sections like “*Mulya bhaneko ke ho?*” (What is a Price?) and “*Khānāko lāgat mulya bhaneko ke ho?*” (What is the investment for food?), market based logics are brought to Humlis, as they are taught how to turn their time, energy, and raw materials into money that tourists will pay them.

<sup>122</sup> The *mit* relationship was a formal, life-long bond that Okada (1957) has likened to a “blood-brother,” and was often passed down along several generations. The *ista* is a more casual relationship that can be severed more easily with little lost in terms of social or economic terms See Fisher (1987: 90-91) and Campbell (1978: 80, 92-94) for in-depth discussions of these relationships.

permanent as the snow on the holy mountain, and the water in the holy lake, and as durable a partnership as the couple of Shiva and Parvati” (Lama 2002: 38-9). These cohesive, trade-based ties existed among other *Karnalivasi*, as well, and were crucial for maintaining livelihood, as they ensured that far-ranging travelers always had shelter, food and drink, storage facilities for goods or animals, and could expect a helping hand or shared resources during difficult times (Bishop 1990: 291).

These trading trips also ensured the seasonal mobility necessary to both graze herds of goat and sheep and obtain goods not readily available near one’s home, or only available in insufficient quantities (Bauer 2004: 127; Fisher 1987: 90; von Fürer-Haimendorf 1978: 352). In short, these “livelihood rhythms,” as Bishop (1990) eloquently refers to them, assured Humlis a relatively high standard of living, a surplus of grain and, through this grain’s conversion, access to other foods as long as several conditions remained constant: Nepal-Tibet cross border movement remained unimpeded; grain brought from Nepal remained more valuable than Tibetan salt; and, the people of the grain producing areas in Nepal’s mid-hills continued to depend on the salt brought down during these migratory trips (Ross 1982). Over a short period of time, all of these conditions would change.

Von Fürer-Haimendorf’s (1978: 250) descriptions foretold of the transformations in livelihood opportunities that would befall Humlis in the following decades, and about which Bishop was already writing. Considering what the influx of salt as a result of the further expansion of road networks from the Tarai into the mid-hills of Nepal would mean for Karnali inhabitants, von Fürer-Haimendorf (*Ibid*, 352-3) wrote,

While no doubt beneficial to the traders of the lowlands, [road expansion] would thus have disastrous effects on the economy of the high altitude dwellers of the northern borderlands...[and] the economic basis of such zones of high altitude as Humla and Mugu may well be irreparably damaged...

The whole of upper Humla is dependent on trade, and it is the recent changes in the trade pattern caused by external factors which threaten the prosperity of the entire region. The people of Humla are painfully aware of the gradual shrinking of their economic base, but neither they themselves nor the administrators concerned about their future can see a solution to the problem resulting from the reorientation of trade both in Tibet and in the lower regions of Nepal.

Von Fürer-Haimendorf went on to write that “the collapse of the vital salt-trade, though clearly foreseeable as a likely development, is not yet imminent” (*Ibid*, 353). However, this collapse was closer than could foresee, and within the span of roughly four decades, livelihood practices based on salt-grain trade caravans were effectively gone. Border negotiations became increasingly difficult, as the Chinese began to more heavily regulate the systems of barter and trade. Conservation efforts in the 1990s created ‘community user forestry groups,’ which purportedly gave villagers responsibility for the management of the uses of forests for foraging and grazing. However, user groups were subject to district level government oversight, and therefore the designation of these groups had the unfortunate consequence of disrupting long-standing patterns of movement by removing traditional grazing pasture lands from mobile traders (Adhikari 2008; Nightingale 2008). Families were banned from the ranges and routes that they maintained and used historically. People sold off their vast herds of sheep and goats as a result (Wagle and Pathak 1997). For one former trader, the loss of these animals was directly related to the hunger many Humlis would later experience: “If we had not sold our goats, famines would not have hit Humla” (cited in Bauer 2004: 130).

Even before these conservation efforts, salt had slowly become more readily available in the mid-hills as a result of Nepal’s planned development efforts to expand road systems, and through distribution programs of government-subsidized, iodized salt to remote districts by the Nepal Salt Trading Corporation, which began in 1965. This was also seen as a public health intervention to curb the prevalence of goiters related to iodine deficiency.<sup>123</sup> Regional salt distribution centers began to cohere around airstrips and helipads, as opposed to nurturing trade-based social and filial relationships across great distances (Bauer 2004; Lama 2002). Nowadays, the rates of exchange between grains and salt are so paltry as to make it unviable for Humlis. According to many Humlis with whom I spoke, one *pāthi* of Tibetan salt is now traded unfavorably for roughly 2½ *pāthi* of grain—compared to previous rates of one *pāthi* of grain (such as barley) for 2½ *pāthi* of salt, the complete reverse (see, for example, von Fürer-Haimendorf 1978: 350). Nearly every Humli I spoke with purchased their salt in Simikot, where it is sold in pre-packaged, one-kilo bags for 8 or 9 NPRs. At anywhere from 45-60 NPRs per kg,

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<sup>123</sup> Personal communication; interview with Dr. Kedar Baral, Chief of the Department of Community Medicine at Patan Academy of Health Sciences (PAHS), 2/17/12.

Tibetan salt is too expensive to be incorporated into current trading circuits. There is simply no profit, or surplus, to be made from this salt exchange anymore.

Other market factors affected foodways and livelihoods in the region. As mentioned above, Structural Adjustment Programs led to reforms in the state-run Nepal Food Corporation (NFC), and this process of neo-liberalization led to the closure of food depots in Karnali districts like Humla, Jumla and Mugu where transportation costs were highest, reinforcing already existing hierarchies in wellbeing across and within regions over the next few decades (Pyakuryal *et al.* 2009).

Food aid flights and lines of villagers waiting for aid rice became common occurrences at district headquarters and food depots throughout the Karnali beginning in the 1970s. Yet, at the same time protests began to take place outside these food depots, as mobile traders began to raise their voices against the new commercial constellations that were forming around the transportation and distribution of salt and grains in Humla.<sup>124</sup> They wanted their voices to be heard as plans involving their livelihoods were being made by Kathmandu elite who had little or no understanding of life out in Karnali, or for whom their own business interests were more paramount than the traders' self-determined livelihoods. In one such instance, several groups of Humli caravaners applied pressure to one of the managers of the NFC to halt the flying-in of food grains and salt, and he was sympathetic to their plight and complied briefly. However, according to Lama (1999: 49), the manager was later brought in for questioning by higher “investigative authorities,” and shortly after airlines resumed their flights of food aid. Another study found that food aid could be supplied to distribution points in the Karnali at half the cost required to fly it up there using goats, sheep, donkey, and people (Khadka 1999). However, when the government explored this and other options—such as using roads that come down through Tibet—airlines cut their prices in half (Adhikari 2008: 186).

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<sup>124</sup> Personal communication, Tsewang “Chakka Bahadur” Lama (Simikot, 2010).



**Figure 6.9** It is rare to see large caravans of sheep and goat in Humla, like this one (only about a third of which is pictured here) emerging from several weeks of grazing in the pastures above the village of Chala.

Today, few Humlis still drive large caravans, but those that do also engage in new forms of economic exchange on their travels. According to three herders I met in Chala on their way to graze in the pastures above Yari and eventually reach Taklakot market, selling a few sheep in the market there would allow these men to purchase several cases of Chinese alcohol, which could be turned very easily into cash profit in Simikot. These three men were from Unapani in southern Humla, and had with them a sizable herd of sheep and goats, perhaps 400 in total. They were unable to stop the herd in the village, so I walked with them for just an hour or so above the village on their way. I commented on the number of sheep and goats, and they said that they had heard of a few big herds in a nearby VDC, but believed theirs was one of the largest remaining in Humla. I asked them if they traded or bought grains, salt, or other goods besides alcohol, and they said that alcohol brought them the most money, particularly when they walked it further south on their journey back to their village. “People drink more now,” one of the herders told me,

echoing what Jeevan Prasad insinuated during our interview. “It is not a good thing, this change, but it is a good source of money for us...People don’t use the sheep and goats for salt in these days, they use sheep for alcohol.”

Alcohol plays both an ambiguous and important role in Humli society. Alcohol is a contributor of vital calories, vitamins, and minerals; it is a home-brewed source of income for many households, though not without gendered dimensions; and is historically engrained in rituals and social exchanges. Alcohol can also be a harbinger of social ills and potential health problems (Holtzman 2009), as several Humlis told me—especially the wives and mothers of those considered to ‘drink too much’ (*raksi sāhrai khāne mānchhe*). During the People’s War, Maoist soldiers would often wander into villages and beat those found gambling and drinking. On several occasions, mostly in conversations with women, I encountered a nostalgia for this prohibition, as money lasted longer when men did not spend it on alcohol, and husbands were less likely to beat their wives when not intoxicated. As Raikes (1989: 453) points out, for women who brew beer, “it is an important source of income, but the irony of it is that it provides an important mechanism for reinforcing women’s subordination, as the drinking is nearly always accompanied by both physical and verbal abuse towards women and children.” Her analysis is relevant to Humla, where alcohol related abuse of women and children can likely be linked to the increasing alienation of communities from traditional livelihood patterns, as men in traditionally patriarchal societies no longer have consistent employment, and are increasingly suffering from the loss of a confirming role within family, society, and agricultural-labor markets. Women and children become the outlet for these feelings of social and economic disconnection, and the direct health implications are nutritional, physical, and psychological; consequently, these dynamics are an important area for future mixed method studies.

Both during and after the conflict, many families continue(d) to brew and sell alcohol to supplement their incomes. The influx of cheap, food aid rice allows many families to do so still now when before they would not brew for a lack of surplus grains.



**Figure 6.10** Home brewed *raksi*, with new and old USAID food aid bags in the background.

Other factors are also merging with the cash economy to shape changes in Karnali foodways. Younger Humlis are less interested in agricultural work, which is indeed a growing trend in the region, and throughout Nepal. There is also a growing preference among Humlis—especially small children and youth—for attractively packaged commodities, which are perceived to be modern. There are now a wide variety of these packaged goods that are flown up to Simikot or brought from Taklakot, including: biscuits, soda, gum and candies, spicy snack mixes, peanut butter, imitation Nutella spreads, chocolate bars and more (most all of which I happily availed myself when in Simikot), and instant noodles commonly called *chow-chow*, which boasts—both pictorially on the package and in English—of vitamins and minerals to make children healthy and help their brains develop. (Figure 6.11) The WFP sachets of multivitamin are potentially attractive to mothers because of the depictions of light-skinned mothers feeding cherubic-looking children drawn on the side of the modern looking boxes of supplements.



**Figure 6.11** *Wai Wai* instant noodles (left), along with other new packaged commodities like cookies, candies, and Coca Cola and Pepsi are available in shops in Simikot, in teashops along the Karnali river trail, and in Humla’s newly created border settlement of Hilsa, which serves as a transit and port of access to Tibet/China at Nepal’s furthest northwest point.

In a timeframe of roughly fifty years, in Humla and throughout Karnali, in a total reversal of the previous situation, people have become much more dependent on food and other goods coming from Tibet and China, and have engaged in new economic activities and foodways. Often these new economic endeavors follow similar routes and paths, but involve different goods and new forms of exchange. Many Tibetan communities north of Simikot, and some Hindu communities, have broadened their economic base by making and selling in Tibet and India *phuru*, small wooden bowls used for eating and drinking. Villagers are also now selling among other things timber, *jaDibuti*, goats, sheep, and even food aid rations in Taklakot or Hilsa for money, with which they then purchase Chinese commodities, such as alcohol, flour, tea, clothes, and shoes. Selling food aid in Hilsa and Taklakot was a common practice, especially the food aid acquired while working on the road. However, the rice is often sold at a price much lower than it is often purchased. Tsering Puti told me that the rice can only really be sold for 30 NPRs per kilo, as opposed to the anywhere from 35-45 NPRs Humlis pay for food aid rice at the NFC. According to him the Tibetans in Taklakot know that the food aid rice is not of good quality, but the money they get in return allows them to bring back other commodities. These goods are highly sought out in the growing number of teashops along the Karnali trail and in the district headquarters, and fetch a good price, particularly alcohol. Foodways in Humla are thus becoming increasingly intertwined with cash, contributing to a “commodification of sustenance itself” (Holtzman 2009: 224) as critical minerals of exchange related to basic subsistence take on new monetized forms.

And, as Humlis continue to purchase goods and sell timber and other forest products in Taklakot, they ride in collective trucks that drive off from Hilsa to the Tibetan plateau and China's interior on a beautifully paved snaking road, which was completed by the Chinese government in less than 3 years (Figure 6.12). Just across from this road is a small metal bridge that connects to the longest running food aid project in Humla, and possibly in Nepal: a WFP Food-For-Work project that involves constructing the Hilsa–Simikot road mentioned earlier. I found that, although most everyone in Humla knew of and had stories about its construction, people's participation in this program varied according to a number of variables, including: how many days were required to walk to the worksite and back; whether the timing of the schedule and the duration of the project period (often three week stints) coincided with other agricultural schedules; if the household could spare a family member's labor; and rumors about how the program was being managed. People spoke regularly of the corruption of the "big people" running the program that stole food aid rice for themselves, or gave more to their *āphno mānchhe*, or did not pay them what they felt they were owed. I had long heard rumors that people were being remunerated with rice based on how much dirt they shoveled, which would then be measured or weighed to determine the allotment.

There were also reports that, during the People's War, Maoist soldiers would interfere with the Food-For-Work program, intercepting villagers returning from work stints and exacting some of the rice. In some cases, this did occur, as the stories of Humlis I spoke with indicate. However, a closer look reveals a more complicated picture in which the social and political lives of food aid rice were rendered highly charged by new movements and meanings of food aid in the face of growing hunger during the decade-long insurgency.



**Figure 6.12** Just across Humla’s border with Tibet, a paved road was built by the Chinese government in less than three years. The WFP-supported Hilsa-Simikot road is supposed to cross the Nara La pass and join up. (Photo: Jeff Masse)

### **Following Food Aid during the Maoist Conflict**

During the ten years of the People’s War, there were media reports of food crises and fears of starving residents in Karnali. Based on my informal observations, household surveys, and interviews from 2004–2010, the conflict had a mixed—though mostly adverse—impact on agro-pastoral and trade practices in Humla, further constraining livelihood practices. The loss of free movement, access to markets, and the ability to work in the fields during the People’s War further constrained access and entitlements to food. Several NGOs visited Karnali districts during the conflict to assess the food security and health situation, particularly of children. One French NGO—*Action Contre La Faim* (ACF), also known as Action Against Hunger—visited Humla and Mugu and produced a report that concluded that the acute malnutrition in the 10 surveyed VDCs was more alarming than expected. They wrote: “We don’t want to sound too

alarmist but the food crisis is already widespread in these districts.”<sup>125</sup> Another report by Seddon and Adhikari (2003) on the effects of the conflict on food security in Karnali describes the situation in Humla during the People’s War as such:

Humla is one of the districts whose population is increasingly worried about their daily lives and livelihoods. In May, when the report was produced, many terraced fields where crops should be growing, lie fallow. Many have fled from their villages, owing to the general sense of insecurity. Of those who remain, many do not have the manpower to farm, or have already eaten their seeds. Others may not have planted this season’s crop for fear that the insurgents will remove it.

However, according to a former WFP employee, “there was no indication of...increases in acute malnutrition or crude child mortality rates. So, on this basis agencies like the ICRC reported that, although the population was living on the edge, there was no humanitarian crisis” (Joergensen 2006: 223). As a result of these mixed messages, little alarm was raised about the potential consequences of increased food shortages and hunger for so many already struggling to meet subsistence needs. In fact, the delivery of food aid to Karnali by the NFC during the height of the fighting decreased in the number of shipments throughout the duration of the ten years of conflict (Adhikari 2008: 180-1), perhaps because of fears of expropriation by Maoist cadre upon its arrival.

There was, of course, good reason to be concerned about hunger during the conflict. In many parts of Nepal, agricultural production declined for certain households as a result of restrictions on free movement, limited access to fields and other farm inputs (human labor, fertilizers, manure), as well as internal displacement and involuntary migration to escape conscription into security forces (Seddon and Adhikari 2003) under the Whole Time program, discussed in the previous chapter. Animal husbandry requiring transhumance diminished further still, and in some instances households avoided acquiring surplus—or tried to hide it if they did—so as not to attract the attention of roving Maoist cadres. Stories of forced donations of food and demands for extra meals at night by soldiers were also widespread. Saubhagya Shah (2008) noted that permission to move about freely was restricted by the Maoists during the People’s War not only because exit was a demonstration of people voting with their feet against

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<sup>125</sup> See the *Nepali Times* articles entitled, “Food for the Karnali,” Accessed October 2, 2012. Available: <http://www.nepalitimes.com/issue/299/Nation/11895>; and “The West is Hungry,” Accessed October 3, 2012. Available at: <http://www.nepalitimes.com.np/issue/2006/05/05/Nation/11772#.UKVSV6NipI0>.

the “new regime,” but it also denied the party its base for labor, tax, commodities and food:

The mobile teams of militia, leaders, and party rank and file had to be fed and housed by the villages along their routes of travel. As the Maoist organization grew, the frequency and the size of party convoys traveling through the hinterland increased, putting even greater strain on grain stocks in a food-deficient region (*Ibid*, 492).

Of course, it was always difficult to ascertain what was really going on in remote areas beyond the purview of the state, but stories emerged from countless sources—international and government monitors, travelers and journalists, and Nepalis who managed to make it out of conflict affected areas—that Maoist cadre regularly exacted donations of grain and other foods from a population already struggling to feed itself. According to Lokjung Shahi of Gothi, “*Maobādi* would come all year. Sometimes we had to feed four or five Maoists a day. Sometimes they forced us to give them food and they cooked it themselves separately...They gave us lots of sadness (*dukha*).” Obtaining food aid, therefore, was important for feeding Maoist soldiers during the People’s War, as many people said. Jagadish Shahi told me, “If we fed them food other than what we ate, they also beat us. And if we said, ‘You have to eat what we have’ (*Je chha tyahi khānu parchha*) they beat us...But they always asked for rice.”

According to my interviews and household survey data, families would sometimes feed up to forty extra meals per month, with nearly all houses experiencing a few visits by army or Maoist security forces. The system for feeding soldiers also revolved around a “chit” system, in which families were sometimes given slips of paper a few days in advance that instructed them to be ready to feed bands of soldiers. This data will invariably differ throughout VDCs in Humla and within communities, based on, among other factors, proximity to military checkpoints and the district headquarters, political ties and sympathies, and a family’s available or presumed resources. However, many people told me that securing enough food to eat during the People’s War was difficult, and that they often went to bed hungry. Bire Bishwa Karma told me in an interview that, “During the conflict there wasn’t any food to eat and no water to drink, (*Khānna khāne pāye nāi, pāni piune pāye nāi*). It was very difficult, we were so hungry.” However, she also spoke of her own fight back attitude, “Sometimes I used to say, ‘You go from village to village gathering up food, why don’t you give us some food?!’”

Conversely, several Humlis told me that their fields were more productive during the

Maoist conflict, particularly the plots higher up that always got more sun and, in previous years, were left fallow because of the time required to walk there and back. During the conflict, however, people would leave early in the morning and come home late at night to avoid harassment by Maoist cadre who wandered into the village. Man Bahadur Shahi also said that many people again expanded their fields during the People's War, whereas the previous trend of allowing cultivable fields to convert into fallow plots or pasture lands had followed the increasingly permanent outmigration after the collapse of the salt-grain trade (Adhikari 2008: 107). Indu Chhatyal told me that people worked a lot harder also because they were afraid to run out of food during the conflict, which spelled trouble if Maoist soldiers came for dinner and you didn't have enough to feed them: "They would beat us...at that time it was so sad. My wife would hold the children just there as she made them rice. They only wanted rice...and if you gave them food other than what you were eating, they also beat you. It was important to have more food at that time."

Some villages were able to keep the Maoists away in a more permanent way. I spoke with Dawa Tundop, a village leader from a Tibetan speaking Buddhist village situated closely beneath the Nara La pass that leads to the border of Tibet. Dawa Tundop was notorious among many communities for having successfully bargained with the Maoists a way out of the WT program and of donations of grains. "We live so close to the border with Tibet, we cut this pass many times so the *Maobādi* needed our help," he told my research assistant Sonam, who translated for me from Tibetan into a mix of English and Nepali. He described how he negotiated a trade with the Maoists, offering to assist with the transfer of equipment for their cadres, such as boots, guns, and uniforms: "The Maoists came and the village people selected me to talk with them. I told them that we would help them unload equipment and clothes from trucks in [the Nepali border town of] Hilsa if they would not come back and ask for food or hit us. I was also surprised when they did not return."

During the People's War, there were many stories and rumors that Maoist cadres were also disrupting the provision of food aid by non-governmental, bilateral and multi-lateral development agencies, including the NFC, the WFP and its affiliate I/NGOs. I found this to be true, and had heard several times that Maoists robbed villagers on their way back from working on the Hilsa-Simikot road, or after obtaining NFC rice at the depot and heading back to southern Humla, where the Maoist presence was notably stronger during the height of the conflict. I heard

one such story from Bhukya Bishwa Karma and his wife Ratna, who described coming back from Simikot with bags of rice on a mule and one carried by Ratna with the use of a *nāmlō* (head strap) when they encountered several cadre on the path who asked them to prepare food for their group. When Ratna very hesitantly refused at first, one soldier pulled out a knife and threatened to cut the bags off themselves and take it. “We were scared for our lives, what could we do? They ate more than half a *katta* of rice...They didn’t give us any money, they only gave us a big scare.”

During the conflict, Maoist security forces were not alone in trying to siphon food aid rice into their stores. In addition to police who were sometimes fired from their post for stealing NFC food aid, bags of WFP rice were also found during the conflict in the camps of the then-Royal Nepal Army (RNA), who routinely declined to turn them back over (Joergensen 2006). Several other stories I heard also disabused the accusations of Maoist forcible extraction of food aid rice. Diki Khando, a Female Community Health Volunteer (FCHV) from a VDC in northern Humla told me that two Maoist soldiers offered to carry her food aid rice back to her village for her, as they saw her struggling with the 40kg bag as she walked. “At first when they called me over, I was very afraid. Then when they offered to help I was so surprised! (*Kasto achhama lāgyo!*). In another interview, two men I spoke with in Chala said that they had sold several of the bags of rice they received through the WFP Food-For-Work program on the road beneath Nara La pass to Maoist soldiers because they could not carry it all back. “We only needed enough rice for the walk back, and some to sell in [Taklakot].” This rice, they said, would be used by the teashop owners to make alcohol, which would then be sold to travelers along the road; perhaps even the same workers returning from digging. Brewing alcohol—especially with food aid rice—is a crucial source of income for teashop owners and households, as many people told me, and the money acquired from selling alcohol brewed with food aid rice is often used to buy other more satisfying foods, such as wheat, corn, and local red rice. One teashop owner, Pundin Lama, told me that most of her family’s money comes from brewing *chāng*, an alcohol popular among ethnic Tibetan groups, because rice, lentils and other staple foods can’t be sold at a high cost to other Humlis. “*Dāl bhāt* costs only thirty rupees,” she said, “Sometimes, people say, ‘Oh, I don’t have money for even that’...But people always have money for *chāng*. If not

for *chāng*, I myself would not be able to eat!” (*Chāng nabhaepachhi ma khānā pāye nāi!*).<sup>126</sup>

As we can see, getting food aid is used in a variety of ways. However, accessing this meaning-filled commodity is not always easy, and it is filled with a range of values, meanings, and consequences as I explore in the next section.

## **Exploring the Cultural Politics of Food Aid Distribution in Humla**

### ***“Getting Rice is About Who You Know”***

In 2007, I interviewed the Humla district Maoist commander, “Comrade Aswhin,” about health camps during the People’s War. It was not easy to arrange the meeting with him, and I was surprised when I first met the commander. He was young like me, at most thirty, and he wore faded jeans and sneakers, and sported a black leather jacket with a Maoist flag sewn onto the breast, headphones dangling out of one of the side pockets. We spoke in Nepali, and his responses to my questions were curt and half-hearted, and our short meeting was punctuated by frequent watch checks as if he was late for another appointment. However, before he left he shook my hand and joked with me that he didn’t know Americans could speak other languages.

Three years later in 2010, I met Comrade Aswhin again on our seventeen-person plane when I was headed up to Humla for dissertation fieldwork. Upon ascending the tiny stairs and entering the plane, he immediately recognized me and I him, and he crouched because of the low ceiling and smiled widely as he came and sat next to me in the rear seat. He now wore dark, pressed jeans and dress shoes, a faded green T-shirt, and a black blazer. His Maoist flag had been replaced by a small hammer and sickle pin. “Do you know me?” he asked me in English. I told him of course I did and we shook hands, and made some small talk before exchanging our respective “greeting cards.” I noticed that he was opting to only speak in less than competent English, despite my efforts to steer the conversation back to Nepali. I asked if he might have

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<sup>126</sup> Among his research in Samburu, Kenya, Holtzman (2009: 205) has also noted how the income derived from brewing alcohol is crucial to livelihoods, particularly for women. During the course of his research (1992-94), he found that 42 percent of the women he surveyed brewed alcohol, and often made money equivalent to or greater than remittances sent abroad from wage labor, or the selling of other commodities like sugar, tobacco and tea. The words of one woman who had no other form of income and was “just surviving on the ration of beer’...invoking the metaphor of relief food for the way selling beer allowed her to survive in these difficult circumstances.”

time for another interview during the course of his stay in Humla. He told me he was quite busy, but assured me he would make some time.

Since our last interview, Comrade Aswhin had become just Aswhin, having risen through the Maoist party ranks to become an elected member of Nepal's Constituent Assembly (CA)—the interim body charged with drafting a new constitution for *Nayā Nepal* after the end of the decade-long conflict and the abolition of the institution of monarchy. Now living in Kathmandu, and representing both the district of Humla and the Maoists, Aswhin had become a pretty big deal—a *Thulo mānchhe* (Nepali, “big person”), someone in a position of great influence with connections to resources and people. When we arrived in Humla, well-wishers and favor-seekers surrounded him, giving hardy handshakes and salutes of “*Lāl salām*.” He smiled in my direction as I watched his homecoming and the fuss around him. “Call my mobile,” he shouted over to me, “We will arrange it.” He was then whisked away up the stairs from the airstrip.

A few days later, I again went to meet Aswhin at a small Lama-run hotel at the bottom of the hill from where I was staying in Simikot. Aswhin was from a Thakuri village located two days south, but his popularity extended to the Maoist supporters in the Lama communities and the hotel owner was one of these supporters. Now that the Maoists were a mainstream political party, support was garnered through favors and *āphno mānchhe*, business details, and perhaps assurances of security. When I arrived, I was directed through several doorways until I found Aswhin in a dimly lit back room drinking Tibetan butter tea and *raksi* and snacking on large plates of fried goat meat, and several bags of packaged chips. “Come sit,” he gestured, and I shook his hand and then sat cross-legged on several blankets (*liyu*) placed on a raised bench adjacent to Aswhin. I was then brought a cup of tea and *raksi*, and Aswhin raised his *raksi* cup to me and said, “Please, drink.” I lifted the cup to my mouth, recalling silently how I heard countless stories of Maoist soldiers beating those who were caught drinking during the People's War.

Our interview was tasty and slightly intoxicating, but also slow and difficult now that Aswhin chose to speak to me only in English. However, the interview proved interesting for another reason. As we spoke, we were interrupted several times by Humlis seeking a favor from Aswhin. The first time this occurred, I just watched as he leaned over to scribble something on a piece of paper that a middle aged Chhetri man had given him, and then pass the paper back to the visitor. An elderly woman came not long after that, and this again occurred. They seemed

thankful, but I didn't think much of it—an autograph, perhaps?—until it happened a third time. This time the visitor was a young woman, perhaps nineteen or twenty. She was dressed in tattered clothes, her hair was unkempt, and she had two big toes protruding from her shoes. She carried a sleeping child on her back wrapped in a shawl. She came in timidly, and once she entered the room offered a *Lāl salām*, and approached Aswhin to ask for—this time I heard—a *siphāris*, a “recommendation.” Aswhin again took the small piece of paper she extended to him and began scrawling. As he wrote, I heard her explain that her husband—who Aswhin later explained had been a fervent Maoist supporter—had been away collecting *jaDibuTi*, but would be returning shortly. She also told him that her three other children at home were all sick and hungry, and I shrank as I sat with plates of meat in front of me. This time I asked him what the paper was for, and he told me that he was writing a recommendation on this woman's behalf for 30 extra kilograms of food aid rice to be given to her at the NFC depot, and he showed me as he signed his name. I asked him if the hand-written chit would work, and he told me that it would help a bit. “If I write 30, she will get 20,” he said. “*Bacchā lāi rāmro sanga pālnus, hai? Bhāt dherai dinus*” (Raise your child well, ok? Give it lots of rice), he said to her, as he finished writing and handed her the chit. She again brought her hands together in a parting *Namaste*, tilt-shook her head to convey understanding and gratitude, and then backed out of the door. Her demeanor, so humble and low, communicated her ritualized deference, both as someone of lower caste and class, and as someone seeking a favor. This is characteristic of *chakari*, an essential concept in Nepal, which traditionally meant to wait upon, to serve, to appease, or to seek courtesy from a religious figure or deity (Bista 1991: 89). As discussed in chapter two, this practice has been firmly entrenched as a social institution adapted into secular life, and in this context, it is a social channel for getting food.

Humilis seek out food aid chits from other politicians, too, which I first learned about from the local NFC branch manager in Simikot, Hari Prasad Joshi. One day while conducting research in 2010, he noticed me watching food aid distribution days outside the depot, and he came over and introduced himself; perhaps I could have been taken for an official or monitor, or a journalist from Kathmandu sent to report on NFC proceedings. When I told him that I was an anthropology student (*Ma ta biddhyarthi ho, mānav sāstra pardera*), he was eager to speak with me and invited me for tea into his quarters, which was located inside the NFC depot. His room was small, and the walls were covered with pictures of Hindu gods, and one postcard from New

York City where I learned his nephew was studying to become an accountant. Both ends of his bed touched two opposing walls, the wobbly wooden frame just large enough to store the two sacks of food aid rice wedged beneath it. He wore a traditional Nepali *topi*, a fuzzy brown sleeveless vest over a plaid shirt buttoned all the way up. His gold watch hung loosely and jangled off his wrist as he spoke about the NFC rice distribution system at the depot.

Through speaking with Hari, I learned that there are four main kinds of rice that arrive in Humla, though the varieties differ throughout the rest of Nepal, and the cost of sale depends on a range of hard-to-pin-down variables:

(1) “Japani” rice, which is grown in the United States and purchased by the Japanese government before being donated to Nepal to supply at a subsidized rate. According to a WFP employee from Japan with whom I spoke in Kathmandu, Japani rice is glut grain from the United States that is pushed on the Japanese government in long-standing, obdurate bi-lateral trade agreements. This rice was currently selling for 40 NPRs/kg in Humla, and according to many Humlis, cooks more quickly with less water than other varieties;

(2) “*Moto*, or “fat,” rice, which is particularly prized for its ability to fill bellies, if only for a short time, with thick, “sticky” (Nepali: *chyāp chyāp*) grains. Many people openly joked about the name of this rice, saying, “*Moto chāmal khāyā dublo bho*” (Even if I eat “fat” rice I become skinny). In 2010, this grain was selling for 37 NPRs/kg;

(3) *Sonā mansuli*—or “gold mansuli”—which is said to have “exceptional cooking quality and is quite aromatic,”<sup>127</sup> was very rare in Humla. When it arrived, it typically sold for 46 NPRs/kg; and

(4) Makwanpur rice, which was the most rare of the coarse grains flown up to Humla, was called so because of the district—Makwanpur—in Nepal from where it came. Over the course of nine months in Humla in 2010, from March to November, the price of the rice ranged from 43 NPRs

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<sup>127</sup> The introduction of the Mansuli variety of rice in Nepal is often credited to Wayne Freeman, an agronomist who specializes in plant breeding, and Gyan Lal Shrestha, who together worked to develop the cultivar from the *Oryza japonica* variety. Freeman first began working on the variety while working as a seed specialist in the Rockefeller Foundation’s Agricultural Program in India. See the article “The Discovery and Journey of Mansuli,” accessed September 20, 2012. Available at: [http://www.ecs.com.np/feature\\_detail.php?f\\_id=497](http://www.ecs.com.np/feature_detail.php?f_id=497).

to 39 NPRs/kg.

The NFC offices in Nepalganj and Surkhet located along the Tarai border were supposed to send a combined 11,000 quintals of rice to Humla in the past year—“And even that is not enough,” Hari Prasad added. However, this year they only sent 6,900 quintals. Typically, even when food or money is allocated for the supply and transport of food aid to Humla, delays, leakages, and flight cancellations inevitably make these figures inaccurate. “There is a lot of famine (*bhokmāri*) here,” Hari Prasad told me. “People only fill half their bellies, *bas* [that is it].” He also described the rice allocation system, where individuals with NFC ration cards can obtain 5kg per person, students can obtain 12kg, and NGO workers get 15kg. “On Sunday, those with ration cards can come get rice. On Friday, [the depot] is open to government and NGO staff. And, if you bring a \*chit\* you can come anytime that the depot is open,” he told me.

I have seen the long lines of people waiting on food aid distribution days outside the office of the Chief District Officer (CDO), who is the highest administrative officer in Humla and oversees all government affairs in the district, including health, education, and security. The CDO’s office is situated just a few hundred yards from the NFC *godām*, and—as with Aswhin—people queued in hopes of meeting with the CDO to obtain a piece of paper that would get them more than their allotted share of aid rice. Here people had to navigate local politics in terms of major political parties. Whether the CDO was from the Maoist, United Marxist Leninist, or Nepali Congress party mattered in terms of inter-village politics, and it was not uncommon for someone to be turned away because of their known party affiliation. The media openly reports on this phenomenon, as in an April 2010 *Kathmandu Post* report entitled “Humla facing food crisis,” which notes that the depot provides rice to local households “on the recommendation of the Chief District Officer and concerned VDC secretaries.” Obtaining this recommendation—a *siphāris*—and potentially getting more food aid, was based on the intersectionality of one’s class and status (student, teacher, NGO worker), alignment with a particular political party, and ability to mobilize ‘source force.’

Humli people have their own views on politics, food aid, and hunger even when they may say they do not. When I asked Humli people about politics (*rājniti*)—while waiting on line for food aid, in their kitchens or fields, on the trail or over a meal—responses were so regularly tempered by comments such as, ‘We are poor here, we don’t know anything about that,’ or ‘What do we know of politics?’ Humlis would often refer to politics as a “game” (*khel*) played

by *Thulo mānchhe* (big people), and in this way separate from politics in the broader sense of cultural relations and contestations pertaining to everyday Humli life. I asked Lundop Lama about politics and food aid one day as he stood in line in front of the depot: “*Tapāiko bichārmā, yahāN khāddhyako chāmalko rājnitikio kura ho ki nahi?*”—“Do you think that food aid and politics are related here?” He told me that nobody here was very concerned with politics, just getting the rice. “*Dah! Rājniti ko bāremā kehi thāhā nahi,*” he said in response (“I don’t know anything about politics”). “*Kāno goru lāi auNsi na puRnā,*” he then added, which is a wonderfully evocative Nepali proverb that translates roughly as, ‘To a blind bull, it doesn’t matter if it’s a half or full moon.’ “I am here to get rice,” he said again, “What do I know of the game of politics (*rājniti ko khel*)?” Similarly, while waiting in line for rice at the NFC depot, Abakanya Malla told me that

[Politicians] fight over who gets to sit in a chair, who goes to NGO (*saNsthā*) meetings and says big things...they all tell lies (*sab jhuTh bolne*). They are those kind of people, they don’t care about us poor people (*Hāmi garibilāi wāsta nagarne tyasto mānchhe*)...Here, we wait in line for food, look...But people in Kathmandu fill their own bellies.

While waiting for food, Humlis are mindful both of their hungry bodies and of the averted gaze of the state (Locke and Scheper-Hughes 1987; Scheper-Hughes 1992). These comments also draw out the distinctions that Humlis make between people, places, and possibilities. “Here” is where people wait in line for food, and “there” represents an imagined elsewhere of plenty.

The *Kathmandu Post* article about Humla’s food crisis referenced above ends by noting that “a high level team from the capital visited the district to take note of the food shortage.” This seems to accurately describe the situation when politicians and other *Thulo mānchhe* from Kathmandu come to Humla, which I have also witnessed. This includes trips from WFP personnel, members of Nepal’s National Planning Commission (NPC) and high-ranking members of the Nepal Food Corporation, who may wander into a nearby village no more than a few hours away. “They come to look and that is it,” the CDO told me during the very short time he agreed to meet with me. “[They] say they have concern for Humli people, for the hunger situation (*bhok ko avasthā*), but actually they do not have concern...only for their own [political] position. So it is on my head (*mero thāplo mā parchha*), the people’s hunger here falls on my head.” His comments about neglect and indifference are similar to those of other politicians from the area.

In a *Nepali Times* (2006) interview from several years prior, Jeevan Shahi, the first Member of Parliament from Humla, responded to a question about why he has not used his political position to try to change the situation in Humla as such:

I have, but Humla is always given the least priority. I have been in politics for 20 years now, and they always say "yes-yes" and then nothing happens. All we need is Rs. 40 million in irrigation for Humla to grow enough food, but I am beginning to suspect there is no interest in making us self-sufficient because the mafia involved in flying food grains to Karnali have a vested interest in keeping us hungry.

Shahi is referring to those involved in supplying, checking, and transporting food aid rice to the Karnali, all those who Humli traders protested as they crystallized their market stake in the provision of relief food. This includes, but is not limited to, private airline and helicopter companies, suppliers of grains in India and Nepal, the Nepal Retail Association, and the Nepal Food Corporation, all of whom make money (officially or otherwise) from this process. The commodity chains and fiscal equations involved in transporting food to Karnali are complex and span both macro and micro-levels of policy and practice, just as the movement of this rice spans great distances and time.

I do not intend a discussion of these intricate and problematic webs of international food assistance, infused as they are with the ethical, political and economic trappings of moving life-giving resources around the world based on a tenuous balance of market principles and humanitarian motives. It is not that they do not concern me. As Pottier (1999) has argued, anthropologists are well poised and, indeed, charged with the task of analyzing the large-scale structural forces that shape food (in)security, while also examining how these forces manifest in the lived experiences of hunger. I, myself, am still sifting through the large bodies of literature, and for now I leave the analyses of the macro-politics of food aid to those who have been studying the topic extensively (e.g., Holt-Giménez 2009; Lappè, Collins, and Kinley 1999; Marchione and Messer 2010; Barrett and Maxwell and 2005). Still, I recall seeing sacks of NFC food aid rice in 2010 being unloaded from helicopters; blank white bags with the exception of a small red tag sewn into the seam, which—for the rest of the day—left me pondering the absurdity of a commodity chain of half quintals of bleached, medium grain, white rice grown in California in 2006 appearing at the Humla depot four years later. Now that I sit here writing, it seems clear to say that something like this can only occur when the state, whose job it is to

ensure its people do not go hungry, has turned a blind eye to these very people; and when the distribution of food aid is not guided by the needs of the intended beneficiaries, but rather governed by capital and global (and regional) markets, from which people in Humla are systematically excluded.



**Figure 6.13** NFC “Japani” rice, grown in California crop year 2006.

The comments of one Chhetri woman from a nearby village sums up rather clearly how the politics of food aid work on the ground: “Look,” she said, “getting this rice is about who you know (*yo chāmal chahi, chāmal samātne chineko mānchhe ko kura nai ho, hernus*). The comments of many other Humlis I spoke with illustrate a similar sentiment of *āphno mānchhe*, highlighting how the seeking, getting, and eating of food can serve to shape and sustain relations and identities characterized by rank, difference, or affiliations (Holtzman 2009: 9; see also Stone 1978)—revealing one form of what Appadurai (1981) calls “gastro-politics.” “They send their own people to the front and our turn doesn’t comes” (*āphno mānchhe lāi agāDi paThāune*,

*hāmro pālo āunna*),” Karka Bahadur Shahi told me, as we observed the crowd outside the depot one day. On that same day, Kunjok Ngyutop Lama said that it was a waste of time to wait when there were big crowds like this, because there were clearly “fake lines” (*nakkali paNkti*): “Staying in line all day and through the night even sometimes...and they are letting people in the back door now!” Chanda Mati told me, “We wait here and there all day, but sometimes they say ‘go home,’ the rice is finished...The staff here only feed rice to their own people...Which party you have to follow, who knows?”

For Bala Lama, a Humli NGO worker who spoke in fluent English, NGOs were also highly implicated in the party politics of *āphno mānchhe* and of getting food aid rice in Humla. In fact, for many in Humla, these organizations are symbolic of new kinds of inequalities, and connections to them distinguish those who “have” from those who “lack.” “In the context of Humla, the NGOs mean the political leaders because each and every NGO is linked with political leaders,” he told me:

Either Nepal Congress, or UML [United Marxist Leninists], or any other parties...Party leaders have their own cadre, and each cadre has their own NGO because they want to have the funding resource from the DDC [District Development Committee], which is easily accessible by the political pressure, and they can benefit from that. And, the other thing is that to get a rice quota, you know, 5 kilos rice, 15 kilos...I don’t know how many kilos they provide for each staff of the local NGOs registered, but for that purpose only, some of the NGOs are registered...

Here, you know the local NGO situation is also those staffs who can tap with the situation and things...They know if they get sick, they can find medicines. They have knowledge of local politics and systems here, but other general people, they lack all these, they have less hope...They are entangled with the bread and butter [sic].

Having connections to NGOs and their attending forms of political patronage and favor—which have made use of already existing social configurations and channels—is seen as a means to both medicines and food. These affiliations allow some people to “tap into” more favorable circumstances, and more readily obtain aid commodities, while others are left simply struggling to feed themselves. In Appadurai’s (2004: 69) sense, those who struggle more readily suffer from a limited “capacity to aspire,” which hinders hope for a better future:

The capacity to aspire is thus a navigational capacity. The more privileged in any society simply have used the map of its norms to explore the future more frequently and more realistically, and to share this knowledge with one another more routinely than their poorer and weaker neighbors. The poorer members, precisely because of their lack of opportunities to practice the use of this navigational capacity (in turn because their situations permit fewer experiments and less easy archiving of alternative futures) have a more brittle horizon of aspirations.

In simple terms, it is hard to get past thinking about one's bread and butter if even bread and butter are hard to come by.

### ***Creative Strategies, and the Violence of Waiting for Food Aid***

As I described in the introductory chapter, I would often watch the distribution of food aid rice at the NFC depot in Simikot. It was easy to spot large groups of people that gathered outside the *godām* from the window of the guesthouse where I stayed, situated as it was on a slope overlooking Humla's district headquarters. Helicopters and planes bringing food aid are also easy to hear from far away, and when one approached a brief siren accompanied the crescendoing whoosh of blades. You could also hear people shout, "*Heli āyo!*" (The helicopter is here).



**Figure 6.14** The sound of helicopters approaching alerts villagers of the arrival of food aid rice.

Sometimes large groups camped outside the NFC depot overnight in the rain with small tarps draped over them for makeshift tents. Sleeping there was sometimes necessary to save their place in line, I was told, otherwise they risked having walked hours or days to find out the rice had run out. There were plenty of stories of this happening. “*Dhilo āyo bhane chāmal sakinccha,*” people would say, “If you come late, the rice will be finished. So we must wait (*basnu paryo*).” A 2010 *Himal* article entitled *Bhātle Dubāyo* (Sunk by rice) describes how people waiting in line in Humla would often finally be told to go back empty handed: “The rice is finished, if you come again maybe we’ll give it” (Bohāra 2067 v.s.: 20). Here, again, waiting is a prominent and permanent feature of seeking to meet basic needs. Yet, amidst the ‘often chronic, sometimes fruitless waiting’ (Chakrabarty 2000, as cited in Jeffrey 2010: 3) that so often characterizes the milling about, pushing, standing and shoving outside the NFC depot, people also fashioned and utilized new creative strategies to access food aid rice in these crowds and lines.



**Figure 6.15** Crowds outside the Humla district headquarters NFC depot on the second day of rice distribution after no rice arrivals for one month; August 2011.

Often family members would stake out a spot on the periphery of the depot compound, leaning on the loosely strung barbed wire, where they could survey the scene from afar. I saw as attendees passed each other chits or—much like the copying of prescriptions at health camps—tried to forge the signatures of officials and allotted amounts. “Does it work?” I would often ask people. “*Kahile kām garchha*,” they would say, “Sometimes it works.” Family members shouted advice to one another on how to get a better position in line, or suggested which NFC staff to try and speak to as they were coming out of the depot. I saw people borrow ration cards, as well: “[The NFC staff] don’t know who is who...we are all just Lamas to them,” one Tibetan speaking man told me. And, just like at health camps, people pressed against one another in lines back-to-front, all the way up to the doors, shoving and yelling at one another. It disturbed me to watch, and often I would leave earlier than I had anticipated, overcome with an uncomfortable mix of voyeurism and privilege guilt, which lingers even now as I recall these distribution days and reread through my notes. This field note entry was from August 15<sup>th</sup>, 2010:

*Yesterday, Sunday, the food depot finally opened and throngs of people lined up to get rice. It was a scene I won't ever forget...In fact, people had been lining up since 7pm the night before. For a few days prior, helicopters had been coming to refill the depot. People were expectant, there were easily 500 people milling about, mostly from Chhetri villages I think...They had two lines, the women waited on the left and the men on the right. The lines crushed inwards towards the doors, which was heavily guarded by police wielding batons. At times the police would push the crowd back, holding their batons with both hands at both ends. The roar of the crowd and the commotion made the scene overwhelming, and I was only watching...People were fighting with one another, swinging arms. Several men and women picked up stones and began to throw them at one another, and then the police started to swing their batons, or raise them threateningly over their head. It was so upsetting. I couldn't make out the content of the argument, and when I asked some people nearby one man just said, "Tension bhayo, u chāmal paye nāi," (There's tension, someone didn't get rice).*

The police were always in attendance at the depot with their batons (*lauri*), and once, in August 2009, I saw armed police force dressed in riot gear in the corner of the compound, though their presence only seemed to inescapably lead to a greater sense of panic. Even as I write up this dissertation, I found a recent media report entitled "Police mobilized to distribute rice"<sup>128</sup> that says they were "dispatched to check the unrest of the mobs" and "pacify the thronging villagers" in Karnali who were clashing with one another to obtain NFC rice, which they knew to be available in insufficient quantities. The violence of chronic hunger and chronic waiting in lines for food is compounded by physical violence when clashes erupt between villagers, and between villagers and police. Sometimes at food aid distribution events, Humlis went home empty handed, with only a taste of the *gorkhe lauri*.

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<sup>128</sup> Accessed September 20, 2012. Available: <http://www.inseconline.org/index.php?type=news&lang=en&id=10530>



**Figure 6.16** Money exchanging hands at the Simikot NFC depot (left); Police form lines in front of large groups of queuing people to keep them from the doors to the depot (right).

Although the majority of police in Simikot were posted there and not originally from the district, they were not removed from the local cultural politics that mitigate access to food aid: as guards of this precious commodity and resource, they are simply too close to avoid it. Police are known to receive more rice than other civic personnel, such as government health workers or teachers. Hari Prasad also told me during our interview that several police officers were fired from their post during the past year for breaking into the NFC depot at night to steal bags of rice. When I asked why they would steal it when they already receive a larger share than other people, he told me quite simply that they do so to sell the food aid. Several teashop owners I met in Humla told me that they purchased food aid to make alcohol from stores that police controlled in private offices not located in the depot. I also met one Humli man from Simikot hanging casually in the back of the NFC compound who told me that he and several police officers were friends, and that he could come back later to pick up his family's allotment to avoid waiting in lines.

I was again reminded of these “economies of affection” (Hyden 1980: 18; see also Ferguson 2006: 95)—and my inextricability from these channels of *chineko mānchhe* (known people) and the reciprocal solidarities friends and (fictive) family perform for one another to ensure livelihoods—when a Chhetri woman came over to ask me if I would be able to help her get rice at the NFC depot. She had recognized me from previous trips to Humla, and knew that I used to be affiliated with one of the NGOs in the district. Like the elderly man I describe in the introduction, she too asked me, “*Tapāiko desh mā tyasto hunchha?*” (Does this happen in your

country?). People regularly posed this question to me when I watched distribution days, intimating to the perceived inequalities between my home and Humla—there and here. As I looked on and thought of how to answer her, I pictured the U.S. supermarkets back home; unseasonal transatlantic fruits and vegetables, aisles lined with bags of dog food as large as the 40kg sacks of rice being shouldered by those successfully exiting the depot. She relieved me of my difficulty in answering when she added, “*Yasto stithi aaunu hudaina*” (This situation should not come).

I explained to her that I was a student conducting research in the district, and I no longer volunteered with the NGO, and I suggested it was probably a bad idea for me to try and cut the line, and then joked that the police would thump me with their batons. “No they wouldn’t,” she said. “The police would never hit a *kuire* (Nepali: slang for ‘white person’).” She was right, and in fact I did walk right into the depot several times to see what happened inside, to take photos, and ask questions. Her comments point to a further recognition of what James Ferguson (1999, cited in 2006: 166) has called “abjection,” or “the combination of an acute awareness of a privileged ‘first class’ world, together with an increasing social and economic disconnection from it.” Standing outside food depots, observing people without enough to eat as they struggle to get food, I embody a vital form of inequality, with a full belly and no fear of a baton.

### ***Alternate Ways of Getting and Giving Food Aid Rice***

After getting the rice, many villages have developed their own internal systems of rice allocation, which exist outside of the allotment policies set by the NFC, and allow certain families in need to collect more than the 5kg per person limit. One day after leaving the NFC depot, I headed back up through the Simikot market and encountered several people I knew from a nearby village sitting outside a small *momo* (Tibetan dumpling) restaurant. They sat astride several giant sacks of recently acquired NFC rice, grinning and passing a pipe full of local tobacco. “*David ji, āunus, bāsnu*,” (Come, sit!), one of them yelled, and pulled me to sit beside them. They smelled of strong *raksi*, as the group of men and women continued laughing and yelling, tossing dirt at one another and sharing cigarettes through cupped hands, as to not make them “polluted” (*juTho*) by putting the end to their lips. They had opened a few of their other bags of NFC rice and, with it sprawled out over a giant green tarp, were engaged in frenzied conversation about how it

would be divvied up once they reached their village. On this day, they were discussing how to funnel more rice into two households that had recently experienced a death, so that the families could fulfill their social and ritual obligations in providing enough food for all who would visit the house that week to mourn and pay respect. Here, then, we see the enduring nature of some communal village ethos, to use Fisher's term, and an instance where obtaining food aid is part of a larger system of collective mutual aid during times of hardship.

Other systems for circulating and potentially increasing the amount of food aid also exist. In one Buddhist speaking Tibetan community north of Simikot, villagers have devised another system for food aid rice allocation. This village is comprised of just over eighty houses in three wards, each of which is allotted 150 kg of rice based on the number of households and family members within each household. However, the village has, over time, come to agree that the five kg allotment always ended up being skimpy by their own measurements upon return to their villages. "They always gave us less," Mingyur Lama told me. "Maybe because we are from Lama villages." So, now instead of each family going to walk and wait in line for their allotted five kilograms per family member, they had arranged for five families to make the ten-hour walk to the district headquarters to collect all the rice apportioned for the entire ward on horses and yak-cow hybrids. Mingyur told me that they had arranged this system through political and familial connections, but this way, people can store up a larger portion of rice that will last them longer, as opposed to the putatively smaller portions—which I was never able to verify—that the staff doles out when individual households visit the depot.

In addition to waiting in line for food aid, Humlis work throughout the year at various times with local NGOs affiliated with WFP making and fixing trails and agricultural terraces (the latter often used for mono-cropping *jaDibuti* to be sold in Tibet), building water taps and schools, and in one case villagers helped construct a helipad for WFP helicopters—a project that arguably limits villagers' capacity to imagine a near future without food aid. Most households I interviewed had at least one member of the family participate in these projects, and for their participation receive one *katta* (40kgs=1 WFP bag) of rice four times a year; though several people noted how these NGOs were not giving out that much anymore to workers in the past year or two. "Before it was like that, they would give us a *katta* each time we worked," Bhukya Bishwa Karma told me. "Now you just don't know. You don't know if you will get the rice when you work or will have to wait for it to come another time."

## Unpacking Food Aid in Humla: The Enduring Taste of Temporary Meals

*Taste is amor fati, the choice of destiny, but often a forced choice, produced by conditions of existence which rule out all alternatives as mere daydreams and leave no choice but the taste for the necessary...which is defined as such only negatively, by an absence, by the relationship of privation between itself and other lifestyles.*

~ Pierre Bourdieu, *Distinction*, 1984

*I cannot nurture hope  
when our tomorrow  
is a movable feast called hunger. It is best  
to bathe in its shadow  
and let this despair grow.  
Hunger is my home  
and poverty the name  
of a village written  
on my heart.*

~ Greta Rana, “Hunger is my home,” 1999

Prabu Shahi described opening a bag of food aid rice to find rotting cauliflower wrapped in a plastic bag, and Kali Bahadur Chhatyal found a shoe in another bag, to which he easily joked, “If they had given me a second shoe, I would have been so happy!” Netra Bahadur found some sugar in his *katta* of rice, which was also a pleasant surprise since the sweet granule is so expensive (250 NPRs/kg) in Humla. I have sat with Humlis as they unpack these sacks of food aid rice and seen, as well as asked them during interviews, what items they have encountered when opening them. This list is quite astonishing, and includes: rocks, clumps of sand and mud, cement, bits of cloth, tire pieces, dead mice, insects, bones, hair, pieces of glass and paper, safety pins, plastic, iron nails and human nail clippings. Of course, what people find when they open food aid rice is not the only factor that shapes their desire for eating or not eating it. What people eat—as well as what people think is “good to eat”—depends on a range of socio-biological, cultural, and political economic factors, such as taste and texture, individual and communal norms, production processes, perceptions of purity, and the ease or difficulty with which it is

obtained and prepared (Bourdieu 1984; Pilcher 1998; Wilk 2012). In the context of Humla, the cultural politics that surround food aid further shape the evaluation of food and eating, and it informs people's perceptions of themselves and their broader social worlds and possibilities.

As Holtzman (2009) has noted among the Samburu of Kenya, introduced foods—especially those from the government or international agencies—are often viewed with various degrees of displeasure, especially as substitutes for historically ample, self-determined food sources. For, “although these [foods] are welcome for the ease of acquisition and as an alternative to starvation or even less palatable autochthonous famine foods”—such as, in the case of Humla, the wildly abundant and health-promoting stinging nettle plant, which many Hindu Humlis only turn to during lean food times—“they are regarded as grossly nutritionally inferior...while also being a source of a variety of social and cultural maladies” (*Ibid*, 118). This was certainly the case in Humla, where many I spoke with expressed a similar distaste for food aid rice, aware of its nutritional inferiority, its inability to stave off hunger, and its socio-political, cultural, and agricultural implications.

However, Humlis do not speak about food aid rice in uniform or consistent ways, even as they compare the rice to their own local foods, and make fluid and nuanced distinctions between NFC and WFP rice and their variable tastes, textures, nutritional quality, and ability to satisfy or not satisfy hunger. To some, these sacks of rice were indistinguishable, filled with tasty (*miTho*) rice, or it was simply “good” (*rāmro*) or “okay” (*thik*), expressed with varying degrees of gusto. To others it was “bad” (*narāmro*), “not tasty” (*namiTho*), or “disgusting” (*gunlāgdo*). People regularly described aid rice as less tasty, filling, or nutritious than other grains. “The taste is so bitter, it makes your tongue swell a little bit. I don't like it. But what to do?” Tsering Lama said as she prepared a large bowl of food aid rice, smacking the side of the metal rice cooker as she held the plastic handle and turned open the top. “It makes your insides feel like they are churning more, like you have worms,” she added as she prepared the rice. The epigraph to this chapter offers Shiva Prasad Jaisi's comment about food aid rice: “*Dui choti pisab gareko yasto bhāt gaisakyo*” (You pee twice, and this rice is already gone). This was a comment I heard by many people in several villages, suggesting that this was not only a common nutritional experience, but a shared gastronomical critique, no matter how playful, with its own circulation and social life.

Indeed, there is pride in local food and its ability to stave off hunger—much more so than food aid—even if people do opt to purchase and eat sometimes old, cheap, knowingly

unwholesome, bleached white rice. As Kali Bahadur Chhatyal poignantly told me,

“Our own food is very good...if we could produce more of our local foods, we could sell it all over Humla and in Kathmandu and China...Look at Humla’s apples, they rot on the fields. Apples alone could feed the people here...We could send this outside rice away and we could have the taste of meals all the time, not just the taste sometimes.”<sup>129</sup>

It seems clear that Kali Bahadur is not really suggesting that people in Humla could survive off apples. His comments point more broadly to a desire to have control over one’s food sources and amounts, and to not hunger for the taste of temporary meals, which are so un(ful)filling.

Despite this tendency to critique food aid rice, the comments by Shiva Prasad Jaisi also illustrate how many Humlis feel obligated to eat and even “like” food aid rice. “What to do?” a common phrase, as should now be clear, “We are poor people and we don’t have enough food, so we have to think it’s good,” he said, even as he acknowledged that this rice can give you diarrhea and does not keep away hunger as well or as long as local foods. This returns us to Pierre Bourdieu’s quote about the tastes of luxury (or freedom) and the ‘taste of necessity,’ which is defined by an absence of other choices in eating: “The former are the tastes of individuals who are the product of material conditions of existence defined by distance from necessity...and the latter by a taste for what [people] are anyway condemned to” (1984: 177-8). As Prem Chhatyal, a Thakuri farmer told me, “*Hāmilāi garibi lāi bhāt namiTho kahāN hunchha?*” (For us poor people, there is no thinking this rice is no good). “The food from our fields is only enough for six months,” he told me, “So, we rely on borrowing food from people here, or *bishwā khāddhya* (WFP) rice...It’s just not healthy for the body, and you are hungry quickly after eating it (*khāera bhok chhito lāgchha*).” Raj Sarki, a metal worker from a village on the border of Humla and Mugu expressed a similar comment: “There’s absolutely no nutrition in this [rice], and it doesn’t satisfy hunger like our food. But, for us poor people, it is tasty (*Hāmi gariblāi miTho lāgchha*) even though it comes with rocks and bones, and sometimes bugs and dirt all-balled up.” In other words, food aid rice is often seen as a “marginal food” (Finnis *et al.*

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<sup>129</sup> Karnali apple farms started in early 1970s, though they were originally introduced in the region in the 1960s by the visiting monarch who had brought them back from Kashmir. Apples from Jumla fetch 70/kilo in Tarai, and in Kathmandu can go for as much as 350 NPRs/kilo, depending on their status as “organic.” But in 2008, by one account, only 5% of the 3000 metric tons were exported from the region, while the rest was used as fertilizer on fields. See “Road to Riches.” Accessed October 2, 2012. Available at: <http://www.nepalitimes.com/issue/2009/09/11/Nation/16309>

2012) precisely because of the local cultural meanings and representations associated with food aid, which intersect with and shape ideas surrounding who eats it, when, and why.

Yet, Humlis would also apologize when they were *not* able to offer me white rice, which is now only available in Humla through NFC or WFP channels. Even when my research assistants and I would request local foods while staying and eating with Humli families—sometimes couching our appeals as part of research on these foods—our explanations often fell short and we were given white rice. “*Bhāt khānu parchha*” (You have to eat rice), people would say. In his book *Food Crisis in Karnali*, Jagannath Adhikari (2008: 18) links this shift in dietary preference to Karnali’s long political-economic history of internal exploitation and derision from the centers of military and cultural-religious power, where rice was the staple diet. He proposes that the predilection for rice reflects a “structure of feeling” of inferiority in the region that extends to local perceptions and practices surrounding growing and eating local foods, and ultimately has implications for food security in the region:

A particular kind of ‘structure of feeling’ of inferiority, humiliation, resignation, lack of self-esteem and dependency was developed in Karnali because of geographical and social exclusion, capability deprivation and domination from external powers. The impact of this feeling in Karnali is seen in considering local food culture, resources, tradition, and local food habits as backwards and inferior. These were then discarded as far as possible and those from dominant culture were adopted. This was also one of the factors causing food insecurity and general underdevelopment in Karnali.

Adhikari (*Ibid*, 71) argues that ‘an incurable symptom of this structure of feeling’ for Humlis is seen in their dependency on government food aid (*Ibid*, 71), which is a common criticism that is levied against both the NFC and WFP, and a charged debate more broadly, too; a topic I pick up again briefly below. I agree with his assertion that the preference for rice has potentially grave agricultural and nutritional implications—as hardy and healthy grains like millet, barley, and buckwheat are wildly more nutritious than old, bleached white rice. For example, there is the same amount of protein in roughly thirteen grams of buckwheat as there is in one hundred grams of white rice (Boharā 2067 v.s.: 21).

However, a preference for rice strikes me as more complex than can be described by a ‘structure of feeling,’ a perhaps over-determined and a not-quite-flexible-enough phrase that Adhikari uses to refer to “a common perception and value experienced by a group of people in a

certain period of time.” To be sure, a shift has definitely occurred, where traditionally grown local foods such as nettles, millet, barley, and *dhiDo* have become denigrated in the eyes of their traditional cultivators as ‘poor people food,’ while rice is often seen as what one should eat. Further, Humlis are much too astute to risk going hungry on the episodic arrival of food aid rice, which is known to be accessible based on a variety of ever-changing factors that range from the weather to a person’s ability to mobilize social and political connections. Food preferences and tastes are deeply and historically localized (Wilk 1999: 253), but also reflect political economic and socio-cultural relationships (Bourdieu 1984). It seems, then, that the reasons for this dietary preference for rice extends to the place rice has historically held in the agro-pastoral and trade-based livelihood of Humlis and the longstanding social relationships the acquisition of this rice sustained; as well as the new forms of social, political, and economic relations it now nurtures.

Still, in the end many Humlis are aware of the detrimental transformations the simultaneously persistent but erratic presence of intermittent food aid may have in the long-term. Netra Bahadur Shahi told me that WFP rice has caused people to leave their fields, echoing Jeevan Prasad’s and many others concerns about the loss of traditional cultivars and cultivators. Food aid also “ruins people’s mouth and thinking,” to recall what Jeevan Prasad said. The comments of many more Humlis point to an awareness of the continued erosion of community ties, local safety networks for food sharing, and a continued loss of control over the ‘when,’ ‘how much,’ and ‘how often’ of eating. This is the bitter taste of temporary meals—the slow erosion of self-sufficiency and, in a larger context, the right to determine livelihoods.

And, despite their hesitance to admit it—so often downplaying their own experiences and knowledge as those of ‘poor and uneducated people’—Humlis are keenly aware of the broader global implications of food aid. Perhaps the words of Dalu Rokaya say it best, who told me and Subash one evening over a dinner of food aid rice that he was aware that this was “waste rice” (*phyāileko chāmal*) from other rich countries like America: “It is like this,” he told us, “Foreign countries have so much food, much more food than needed...so the best food goes to that country’s people first, so the rice, too, the best rice is eaten first and then the leftover (*bāNki*) rice is sent here for us.” Subash asked him what he thought about this apparent arrangement, and he then inserted a local proverb to finish his response: “*Kyā na pāyāN pāunāle hochi, bāsi roTi laglāNyāN gharināle hochi.*” This translates roughly as, “Oh, look what I have received, the guest thought [happily], while the shopkeeper thought [cleverly], I know, I’ll make bread (*roti*)

with the leftovers.” Dalu’s comments point to the larger political economic relations of inequality that are structured and experienced vis-à-vis the pursuit and consumption of certain edible commodities, and highlights how food connects people and places—real and imagined—around the world (Finnis 2012; Friedmann 1999; Lind and Barham 2004). In this idiomatic instance, Humlis receiving food aid are the guests receiving bread, perhaps supposed to be pleased at whatever it is, while the countries donating food aid rice—the foreign actors and institutions that comprise a larger, now ever-present nongovernmental government—are the shopkeepers, cleverly getting rid of leftovers in order to make a dollar. This changes that taste of things.

## CHAPTER SEVEN: CONCLUSION

### **Dispensing (with) Health and Hunger? Thinking Beyond Short-Term Practices of Care**

*Loss, mourning, the longing for memory, the desire to enter into the world around you and having no idea how to do it, the fear of observing too coldly or too distractedly or too raggedly, the rage of cowardice, the insight that is always arriving too late, as defiant hindsight, a sense of the utter uselessness of writing anything and yet the burning desire to write something, are stopping places along the way.*

~ Ruth Behar, *The Vulnerable Observer*

#### **A Personal Departure**

Seattle's rain plinks against my window as I sit at my desk looking through photos of Humla and rereading my journal entries, word-smithing, reflecting on how this manuscript represents the culmination of seven and a half years of anthropological training and intensive research, yet also—to borrow from Ruth Behar's beautiful prose above—only a stopping point along the way. I know that the words contained here cannot do justice to the people who have told me their pain and sorrow and laughed with and at me, who shared their food and homes with me, who asked me what my study will do for them. I wish now—as I've wished countless times throughout this lengthy writing process—that I could call my friends and research assistants in Humla to ask them something, or be instantly transported back to a certain village rooftop to ask another follow up question, or to check with an entire group of people sitting around a fire if I had this and that Humli meaning correct. All of these people have been in my heart as I've struggled with this analysis and write-up process, but right now I miss them more than ever as I try to take what I've learned and end this dissertation in a meaningful way.

What did I miss? Is what I've shared accurate, or insightful enough? How could I have made the historical points and contemporary linkages I've tried to illuminate clearer? Will this study inform policy in any way or have any concrete impact on the livelihoods of Humli people? Have I misrepresented, romanticized, or overly impoverished through my descriptions? How do I

submit this dissertation to become a PhD and accumulate more social capital knowing that so many of those whose lives I've represented remain ill or hungry, or ailing in some other way that this long document may never redress? I know I cannot answer these questions just yet. Ultimately, I am left to hope that this continued research is in the service of making contributions to Humli people's long-term struggles in seeking an end to sickness, hunger, and suffering, as well as the means for new life possibilities in what many are calling, as if to conjure, a "New Nepal."

In this final chapter, I'd like to review the ground we've covered and then reflect on what we might conclude from an examination of contemporary models of short-term care in Humla. The remaining structure of this chapter is as follows: In the next section, I revisit briefly the main points of the preceding six chapters. I then discuss lessons learned in the context of medical volunteer programs and health camps, then food aid programs, and I discuss some practical recommendations. Ultimately, I argue that these models of short-term care shape people's lives in unexpected and often immeasurable ways. And, while they offer tenuous, if unequal, benefits, they do so at the cost of diverting attention from the larger social and political changes needed to promote and sustain health and wellbeing. They undermine state sovereignty while simultaneously disabusing the government of responsibility for ensuring right livelihood the Nepali people. The voices of those intended to benefit from these models of intervention—whose experiences, hopes, and livelihood strategies are reconfigured as a result of them—make this clear, and therefore they must also be brought to the planning table. We have much to learn from each other.

### **Retracing My Steps**

In this dissertation, I have woven together the threads of multiple bodies of social science scholarship and theory along with my ethnographic data to examine short-term models of care—specifically medical voluntourism, health camps, and food aid programs—as a current incarnation of 'governance through nongovernmental government' in Nepal, and as a broader indication of the increasingly ephemeral nature and forms of contemporary global health, development, and humanitarian policy and practice. Based on my analysis from more than two

and a half years of ethnographic fieldwork—particularly archival research, interviews, and participant observation—I propose that, in their continued coming and going—what we might call their ‘prolonged transience’—these prevailing models of short-term care have social, political, economic, medical, and agricultural traces and (after)lives, which impact livelihoods in material ways and also inform people’s perceptions of their immediate and imagined worlds and possibilities. These short-term interventions of care also recalibrate—perhaps we can say diminish—Humli people’s aspirations for whether and how these worlds may someday be different. Perhaps this involves imagining a Humla that no longer requires the flying-in of medical volunteers, health camps, and bags of food aid rice.

In the introductory chapter, I framed the emergence of these models of care in Nepal’s emergent developmental and healing landscapes following the country’s putative “opening” in 1951. I then laid out the theoretical frameworks and conceptual tools that inform my study, and offered two ethnographic vignettes to introduce medical volunteer stints, health camps, and food aid programs as prominent and problematic models of short-term care and nongovernmental governance in Humla, and to contextualize my research questions, which sought to examine: (1) how those who participate in short-term models of care experience them both during and after these events have come and gone; (2) how the presence of short-term medical volunteers, health camps, and food aid programs shape experiences of health and healing, and hunger and eating in Humla, and how Humli people interact with these fleeting forms of care to meet their healing and eating needs; (3) how short-term models of care shape local Humli ideas of about their worlds and imagined worlds elsewhere; and, finally, (4) what these models tell us about larger transformations in ‘nongovernmental state power’ and resilience in the face of these shifting relations.

In chapter two, I engage with and build on the geographical heuristic of “Zomia” proposed by William van Schendel and popularized by James Scott to explore how communities who have lived in the Himalayas and other areas of “mountain fastness” have historically negotiated various unpredictable state making and governing forces with creativity, in which we can now include the transient presence of the growing numbers of NGOs and other development and humanitarian assemblages. In attempting a ‘historical reading against the grain’ of existing scholarship and popular representations of the Karnali region, I located the determinants and extant conditions of poverty, sickness, and hunger in the region’s long legacy of exploitation,

socio-economic oppression, and institutionalized underdevelopment. Critically retracing Karnali's complex sociopolitical and cultural history also allowed us to see how it came to be known and represented beyond its boundaries—and even, to some degree, internalized by those who live there—as an ‘out of the way place’ with inhabitants who are mostly poor, sick, and hungry, and therefore desperately in need of medical interventions and food aid. In chapter three, I described briefly some of the sounds, sights, textures and rhythms of life in Humla when people are not seeking out medical volunteers, or waiting in line for health camps or food aid programs, which are the topics of chapters four, five, and six, respectively.

Chapter four examined the social and political lives that surround *bideshi* medical volunteers as they circulate in Humla as part of emergent forms of global health work and travel, which are both part of a long history of foreigners coming to heal and ‘do good’ in the remote mountains of Nepal, and also part of the new and ever-expanding transnational nongovernmental government of health. I revealed the stark differences in motivations, experiences, and aspirations—medical, social, and material—of volunteers and the local health care workers and Nepali villagers with whom they interact. Specifically, I argued that medical volunteer experiences—while beneficial and transformative for the volunteers themselves—can burden and disrupt local health care efforts, encourage in instances of medical harm, create and reinforce inequalities, and contribute to the medicalization of health and other unmet needs.

In chapter five, I turned to explore health camps as another site of fleeting care, and examined the social and political lives that surround medicines obtained at these camps. First, I examined the more sinister history of the medical camp model in South Asia and located its emergence as a paradigmatic model of short-term health care in contemporary Nepal used by NGOs, military cadres, and the state, which, I argue, politicizes the movement and meanings of medicine and furthers Humli people's ambiguous relationship to seeking out medical care provided by ‘outsiders.’ The stories and experiences shared with me by my research participants also revealed the multiple and complex ways in which health camps are sites of resilience and creativity, as attendees seek out medicines as meaning- and use-filled commodities, and the diverse ways that they are used to meet a range of basic needs during times of war and in settings of structural violence. These uses point to biomedicine as just one part of a plural medical system in Humla where multiple therapeutic modalities blend, and they also point to instructive instances of de-medicalization on the part of Humli camp attendees.

In chapter six I discussed recent changes in livelihoods and foodways in Humla to contextualize my broader argument about the ways in which food aid programs and the rice acquired through these programs both come to stand for and index broader social, cultural, political economic, agricultural, and gastronomic changes in the district, which include the loss of long-standing social ties and community cohesion, changing patterns of migration, trade, and work, and the increasing commodification and politicization of sustenance itself. At the same time, food aid rice contributes to changes in local ideas about food, eating, health, and hunger. Through highlighting the social, political, and (agri)cultural lives of food aid rice obtained intermittently and in unpredictable ways through the district of Humla, I also illustrated that Humli people use this rice for a variety of needs not immediately associated with eating; however, the “taste” of rice is often unpleasant due to its broader implications for society and indications of global inequalities, namely, as a donation from rich countries to poor countries purchased by (materially) poor people who cannot go to these countries, but undoubtedly hunger to know them.

Collectively, the data in these chapters reveal the changing forms of intervention in Humla as increasingly fleeting and episodic in nature, and the many ways that they fail to accomplish what they set out to do yet achieve a great deal else. These lessons—far from critique for the sake of critique—highlight the ways that these short-term models of care reconfigure and constrain experiences, practices, and ideas that surround health, medicine, food, eating, and hope for improved livelihoods. These findings also point to the ways that these models unhelpfully separate out the inexorable experiences of health and hunger from one another, ignoring how they are ensconced in larger struggles for wellbeing.

## **The Inextricability of Health and Hunger and the Partitioning Practices of Ephemeral Care**

### ***Can We Do Better than Short-Term Medical Volunteer Programs and Health Camps?***

I'd like to reiterate my initial caveat about not arguing against the use of medicine in places where common ailments can kill. To that, I'd also like to add that I am not suggesting that people should not participate in medical volunteer programs. In conditions that do not promote health,

medical camps can fill a need.<sup>130</sup> Moreover, small-scale, specialized camps—such as dental camps, cataract camps, uterine prolapse, and orthopedic camps—can undoubtedly transform lives. No one can oppose the judicious use of medicine to treat and save someone who is ill or suffering, as Didier Fassin suggests (2009: 133). However, I take issue here with an over-emphasis on treatment: for example, conducting orthopedic surgical camps that offer no opportunity for post-operative physical therapy; dental camps that forgo educational components on oral hygiene and changing diets; or prolapse camps that remove uteruses without offering locally appropriate psychosocial services (cf. Wall et al. 2006: 562). Considering these interrelated issues forces us to think of health and wellbeing in an expanded sense, beyond purely medical domains. Hari Chandra, a local school teacher I met several in 2007 while walking through upper Humla with my research assistant and friend Sagar, offers this analysis:

How we are living way out here is very complex, very sad. The people who organize health camps do not understand...To make one healthy, it is necessary to take concern on eating and drinking, but where and how can we get nutritional food? And, if people are thirsty, and they think water is good for health, shouldn't this water also be clean? To me, the health camp is a distraction from these issues.

Medical volunteer programs and health camps may simultaneously feed and increase dependence on the magical attraction of foreigners and foreign medicines (Harper 2003). Further, unnecessary surgeries and overeager dispensing of medicines in the context of unmet basic needs is dangerous, and disingenuous. Continuing to run health camps and medical volunteer stints may come to epitomize what Paul Farmer (2003: 203) calls “medical futility”—the instances where medical care is painful or dangerous, expensive, and prolonged well beyond the point of efficacy. In the long run, camps might also cause more health-related problems when surgeries are conducted in unsterile rooms or without proper or any follow-up, when diagnoses are made through translations, or painkillers, antidepressants, and antibiotics are given out haphazardly. The possible forms of antibiotic drug resistance should also be a concern here. Vitamins, worm tablets, and ibuprofen—among the most readily given medications by medical volunteers and at health camps—can also cause gastrointestinal problems such as constipation or ulcers when taken with too little water and food (DeCamp 2007: 22; Roberts 2006: 149), which is a very real

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<sup>130</sup> And, of course, temporary medical camps in the wakes of natural disasters or refugee camps in the context of wars are another issue, though not without their own sets of ethical and practical complications. See, for example, Fox (1995), Lee (2005, 2008), McKenzie (2005), Redfield (2005), and Rieff (2002).

concern in Humla. Even Oral Rehydration Solution (ORS), meant to stave off death due to diarrhea, can be counterproductive when made with contaminated water, and ORS mixed with too little water can increase dehydration (Werner 2001: 22).

Calling these interventions *health* camps—where surgery and dispensing pills are the most prominent features—risks obscuring and depoliticizing the reasons people become ill in the first place, and what really causes health. In the language of critical medical anthropology, this is known as the medicalization of health—when medicine is used to try and solve problems that are ultimately social, political and economic in nature, and when the conditions that foster scarcity, sickness, and suffering are stripped of their human origins. As Scheper Hughes (1992: 214) reminds us: “We cannot forget that whatever else illness is...it is also an act of refusal, an oblique form of protest, and therefore, it too, can contain the elements necessary for critique and liberation.” However, “once safely medicated, the scream of protest is silenced, and the desperate message in the bottle is lost.” So, what is the message?

One controversial but crucial lesson emerges from recent studies in industrialized nations, which indicate that population health is about more than just medical care and that, historically, mortality responses reflect varying traditions of social justice, community organization, and resource distribution (Bengtsson et al. 2004; Bezruchka 2006; Krieger 2007; Navarro 2002; Wilkinson 1996, 2005; Starfield 2000; Wilkinson and Pickett 2009). This point is particularly relevant in the context of new global health efforts. As the growing number of global health programs at universities and health centers incorporate international training and health care service opportunities (Crump and Sugarman 2008:1456; Kanter 2008), there is a need for thoughtful, inter-disciplinary discussions about the ethics, shortcomings, and benefits of fleeting medical programs, and how they land—often, quite literally—in complex terrains of situated medical knowledge and experience, and settings of privation and conflict. It seems clear now that this discussion must center on these programs’ potential contribution to local struggles for social justice, particularly those surrounding clean water, food, and education—some of the most important determinants of health, and hope.

From the perspective of health care delivery, DeCamp (2007: 23) and Green et al. (2009: 11-12) offer further questions worth thinking through: Has the community been involved in the planning of the medical program? Are care seekers and their families happy with the care provided, and why or why not? Is the care received culturally appropriate? What does that mean,

and to whom? Has the means for evaluating the potential unintended consequences and long-term impacts of short-term medical intervention—on the communities, the coordinating organizations, and the national health system—been planned? Bezruchka (2000: 78), too, offers sound advice:

If you must go, focus on one country or region; learn the local language; and learn about the local health problems, as well as the systems of traditional and introduced care. Respect local cultural norms. Do not further propagation of the US-centered, global monoculture. Consider your strengths and what you have to offer. Teach appropriate skills using the limited locally available resources, and *sign up for the long haul*, at least in spurts (my italics).

I return to discuss what ‘signing up for the long haul’ means in terms of a larger vision of social justice beyond reforming these imperfect models of intervention, and their broader implications as a form of nongovernmental governance that challenges state sovereignty at the end of this chapter.

While there is a need for more research on short-term medical volunteer work and other kinds of tourisms as they develop and take shape in other contexts (see for example Baptista 2012; Feng 2012; Mathers 2012), arguably enough has been written on the subject to move towards action. The formulation of recognized ethical standards and best practices for short-term medical volunteer programs is a necessary and promising area for future collaboration. Some have already begun the task of creating guidelines, which can be used to evaluate and develop existing and new programs, as well as serve as the basis to withdraw programs that do not comply when necessary (DeCamp 2007: 23; Suchdev et al. 2007; Sugarman 2007: 1458). In particular, the “Ethics and Best Practices Guidelines for Training Experiences in Global Health” written by Crump *et al.* (2010) should be disseminated widely, and used as a standard for service initiatives and other university-affiliated programs. Some critical companions for volunteer service and global health trips have recently emerged, as well, such as *A Practical Guide to Global Health Service* and *Awakening Hippocrates: A Primer on Poverty, Health, and Global Service* (O’Neil 2006a; 2006b). Several forums committed to having critical discussion about the ethics and impacts of short-term overseas engagements and service projects have already been created, and more should be encouraged. Typically, these are affiliated with institutions located outside the United States. The University of British Columbia’s platform called “Ethics of

International Engagement and Service-Learning Project (EIESL) and the University College London's "Hitchhiker's Guide to Global Health" are just two examples of creative and interactive toolkits that deserve widespread dissemination.<sup>131</sup>

NGOs that facilitate health camps and volunteer programs can play an important role here, just as they have in creating NGO codes of conduct aimed at strengthening national health care systems (e.g., Health Alliance International 2009). A publically accessible list of signatories to an 'International Medical Volunteer Code of Conduct,' for example, could contribute to building transparent partnerships between health ministries, funding institutions, and NGOs. It is just a piece of paper, but it is a start. It would also provide a reference for volunteers and those who plan service initiatives to work collaboratively with organizations that focus on long-term professional relationship building and training programs conducted in accordance with MoHP priorities (cf. Pfeiffer 2003: 736), which should be a guiding objective of global health work. In the end, this may help build collaborative, mutually beneficial projects that support already existing infrastructure and public sector health workers and systems.

On a national scale, Nepal's Social Welfare Council—which oversees the work of many NGOs—and the Nepal Medical Council—which registers international medical workers—should also coordinate with the MoHP to take the lead in these efforts. Those who run health camps and medical volunteer programs, especially in the same regions, must coordinate more with one another. Otherwise, they risk duplicating or further fragmenting service delivery. These organizations must also be held more accountable to local health care institutions, particularly district level health offices. Ultimately, these are issues of state sovereignty, and the ability of Nepal to define the agenda for, as well as control the kinds of, medical services being delivered to its population. Global institutions such as the WHO—which recently reconfirmed its commitment to the idea of Primary Health Care as enshrined in Alma Ata at their Southeast Asia regional meeting in Nepal (see also WHO 2008) and established a Global Priorities for Patient Safety Research initiative to, in part, look at the "epidemiology of harm" (Bates 2009:1242)—will also have key roles to play in discerning the potential harm that might come from caring in the short-term.

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<sup>131</sup> See also Good Intentions are Not Enough. Accessed November 01, 2012. Available at: [http://informationincontext.typepad.com/good\\_intentions\\_are\\_not\\_e/2009/07/guideline-1-for-volunteering-overseas.html](http://informationincontext.typepad.com/good_intentions_are_not_e/2009/07/guideline-1-for-volunteering-overseas.html)).

In September 2008, a Maoist-led government announced a keystone public sector program in *Naya Nepal's* first federal budget that aimed to provide free health care services, including village-level scale up and free maternity services, to all Nepali people (Peterson 2008). The “New Nepal: Healthy Nepal” initiative was, at least at the level of thinking, a conscious effort to begin to repair damage done to the health care system during the conflict. However, the plan never saw the light of day because the Maoists pulled out of the government, and the next coalition government jettisoned the plan, as is commonly done. Nepal’s current implementation plan for the 2010-2015 Health Sector Programme continues to assert adherence to the principles enshrined in Alma Ata, which is hopeful.<sup>132</sup> However, it also lists “increasing mobile health camps” as a working strategy for improving quality service access in remote areas (NHSP 2010: 108). Until the people of Nepal see the actualization of a government’s rhetoric for affordable, accessible and enduring primary health care services, they may be forced to negotiate the ambiguous presence and afterlives of short-term health camps and medical volunteers, as they continue to do with agency, creativity, and resilience—thriving in the spaces in between.

For now, it seems like medical volunteers and health camps are here to stay, therefore in Appendix B, I provide an ethnographic ‘post-script’ discussion of recommendations for medical volunteers as they described them to me, as well as an overall synthesized set of recommendations for medical volunteers and participating organizations. This is primarily an effort at harm reduction, but it also provides a starting point for potential medical volunteers to critically evaluate the potential risks, rewards, and implications of participating in this model of short-term care. In the end, I summon the words of Adrian one more time, as he reflected critically on his presence as a medical volunteer and his impacts on people’s health and hopes to arrive at a conclusion with which I so strongly agree: “It seems pretty clear that we can do better than this.” It seems clear that we can do better than ‘better than nothing.’

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<sup>132</sup> The MoHP 2065/2066 (2008-2009: 6) Annual Report for the Mid-Western Regional Health Directorate notes that, in accordance with the “spirit and feelings” of the *Lokāntra Āndolān*, the largest political agitation in Nepali history: “We express our strong commitment to the world wide recognition of ‘health being the basic right of people.’ Our special focus will be on people of economically and socially deprived groups, sex, tribes, communities and regions to guarantee the health of the overall Nepali people... Toward primary health care, the services will be provided according to the proclamation of the Alma Ata Declaration.”

### ***Short-Term Grains or Long-Term Gains? The Implications of Food Aid Rice on Hunger and Hope in Humla***

This research also calls for a rethinking of the persistent use—as well as the assumptions that undergird the use—of food aid in places that suffer from chronic privation and other unmet basic needs. This conversation must shy away from sweeping condemnation, and instead focus—as I have tried to do—on grounded analyses in specific places and contexts, disaggregating and mapping the experiences, impacts, and uses of food aid. As with the case of health and health camps, we must ask the question about the underlying determinants of hunger and the implications of short-term fixes: Do food aid programs address hunger? My research affirms the complexity of asking such a question. For while food aid may be a tool used with varying success to address food shortages, it is difficult to know if food aid addresses hunger, which is a lived, embodied, and constantly changing experience, subject to varying intensity and interpretation. Beyond this, as I have shown, Humlis satisfy a range of needs in a range of ways with food aid, not just needs of the belly. The implications of food aid in Humla, therefore, seem more social, political, economic, and gastronomical than mainly nutritional.

Nevertheless, it strikes me that the long-term—seemingly perpetual—use of intermittent food aid to solve chronic hunger is not unlike periodically taking one or two antibiotics when the symptoms of respiratory infection flare up on a steep climb. In this situation, we (in the global north) would never say, for example, ‘Oh, just take one or two antibiotics—it’s better than nothing.’ Why, then, is this so readily the argument used in defense of food aid? Drawing out more clearly these food-medicine similarities, and beginning to sum up nicely a larger argument I am making in this dissertation, Adhikari (2008: 168) astutely writes:

In short, despite growing problems of food shortages and food insecurity—manifesting periodically as local famines—which are the consequence of a complex nexus of political, economic and social changes in the region and its relationship to the wider world, development intervention has remained extremely limited...The government—and, for the most part, international development agencies—interventions have been directed towards the mitigation rather than the resolution of the underlying problems, and could even be said to have contributed to the difficulties of the region. Just like an incomplete course of drugs can strengthen bacterium or virus responsible for illness, inadequate intervention can worsen the situation in medium and long run, and arguably, even in the short run. An example is the distribution of subsidized food.

Some argue with even more force against the continued use of food aid in Humla. Writing in an editorial called “Don’t Kill the Karnali with Your Aid,” Humla’s former MP Jeevan Shahi writes: “The forced dependence on outside food has caused an erosion of our traditional self-sufficient pride and dignity. We can do perfectly well without the rice, thank you.” Janak Nepal has also suggested that dependency on food aid has already pushed the region’s agriculture production to a dismal state, and that, in short, food aid simply is not working as a strategy to address hunger.<sup>133</sup> Their words resonate with those of Edkins (2000: 68), who writes that, in many ways, “the ‘failure’ of food aid programs is central to their ‘success,’ as they produce and reproduce relations of dependency between first and third world states and within those states.” Surely, the case of the nearly two-decade-long Food-For-Work program in Humla is an example of this—where the failure to achieve the end result of the work is justification for continued use of the intervention. Indeed, it is now quite common to hear this assertion that food aid may perpetuate the very crises it seeks to stem by providing disincentives to grow other local, more nutritious grains. My observations in Humla prove this to be both true and hyperbole. People are indeed growing less traditional grains than before, though to what extent, I cannot say. The reasons for these changes, as I discussed in chapter six, are complex and steeped in shifting agropastoral patterns and the dynamics of a more strongly emerging cash economy. A confluence of other factors intersect with the changing regional political economy that range from new crop diseases, shifting weather patterns, and the changing dynamics of marriage, kinship, and social ties, as well as declining interest in agriculture on behalf of younger generations. The presence of food aid, then, is one more factor that is contributing to these changes.

Nepal’s WFP Country Representative Nicole Menage further challenges the legitimacy of claims of dependency by saying they’re simply not true. Food aid, she said in a recent *Nepali Times* interview, is meant only as a supplement for households in remote regions: “Those who accuse us of creating dependency should ask themselves the question: what would happen if the assistance were not there?”<sup>134</sup> Again, this ‘better than nothing’ argument ends up looking more like an excuse upon which the management, rather than the confrontation, of different forms of

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<sup>133</sup> “Food deficiency calls for lasting measures.” Accessed October 10, 2012. Available at: <http://www.ekantipur.com/the-kathmandu-post/2011/08/28/development/food-deficiency-calls-for-lasting-measures/225661.html>

<sup>134</sup> “Fund Insecurity.” Interview with Nicole Menage, *Nepali Times*. Accessed March 11, 2012. Available at: <http://www.nepalitimes.com.np/issue/2011/04/13/Interview/18104>

inequalities in livelihoods and self-determined futures are based.

It turns out that we will soon be able to see for ourselves, as the economic downturn of a few years ago has caused WFP to often suspend helicopter operations and reduce the number of targeted individuals by 600,000 in 2011. The fiscal constraints, Menage reports, stem from both the global recession and changing donor priorities in moving out of post-conflict, humanitarianism to a focus on developmental work. “Nepal’s silent emergency,” she said, no longer “falls into the traditional humanitarian slot.” I agree here with Harvey *et al.* (2010: 31), who suggest that “rather than labeling food as humanitarian and other instruments as developmental, it is more helpful to think about how modalities and objectives of different food security instruments may shift as transitions from humanitarian to development approaches take place” (Harvey *et al.* 2010: 31). This debate around dependency is very volatile, however, I agree here with scholars have noted how these conversation often reflect more the concerns of those who make policy and procure and transport food aid rather than the concerns of those who receive it on the other end (Barrett and Maxwell 2005; Edkins 2000).

This last point is particularly relevant because Humli people do not make these discursive distinctions. The people I spoke to about food and hunger in Humla did “not build definitional firewalls between malnutrition and famine, poverty and starvation” (Davis 2002: 21). Their daily struggles for food and wellbeing largely exist outside these debates. And, they have now begun to develop alternate livelihood practices using food aid to meet other basic needs and desires. However, despite the discourse and talk of dependency on food aid in Humla, Humlis are too savvy, and have too much experience negotiating uncertainties of life in the mountains to risk staking their hunger on the arrival of food aid rice that they know comes infrequently, is obtained unpredictably and sometimes dangerously, and only satisfies halfheartedly. So, I suspect we do not have to worry about dependency as much as we should be concerned with how a reduction in food aid will further shape livelihood patterns, life chances, and aspirations on the ground. It will likely generate new fears and representations—as well as internalizations—of food crises and famine, while simultaneously galvanizing the resilience and creativity of Humli people in new ways.

Moving away from protracted humanitarian relief operations will mean a gradual decline in food aid to places like Humla, the implications of which are uncertain. Yet, a switch to more assets-based and monetized forms of assistance might enable local people to begin developing

their own appropriate responses to food shortages and experiences of hunger, though again, this will have to be explored further as it unfolds. As it does, organizations like the WFP should begin to shift attention to nurturing local food production, and enlisting Humli farmers in the planning and implementation of these efforts. In the words of Gorakh Bista of Srinagar, in southern Humla: “If we grow the right crops, there is no reason we can't produce enough food for ourselves” (cited in Mahato 2011). Bista points to *kāguno* and *chino* as examples, two kinds of locally grown millet that are both hardy, nutritious, and grow well in a dry and cold climate and can be cultivated from the lowlands to the highlands without much water, making it perfect for places like Humla. Scientists at the Nepal National Agriculture Research Council (NARC) agree that there should be a renewed focus on these crops. In the Underutilized Crops Unit contained within NARC, scientists such as Resham Amgai and Sumitra Pantha have been collecting local varieties, carrying out studies on yield, and recommending varieties of hill crops—such as buckwheat, finger millet, *chino*, *kāguno*, barley, and amaranth—for local production and commercial release for some years now. However, they recognize that the challenge may lie now in coaxing the taste buds of the cultivators back to these hardy, nutritious grains.

It has also long been suggested that the wide, sun-soaked low-lying valleys and fertile alluvial terraces of southern Humla could produce enough food to feed the entire district, and even other parts of the Karnali (*Nepali Times* 2006). Lift irrigation schemes operated using micro-hydro power is one example, which my research assistant, Subash Chandh, who is also a development scholar and trained engineer, has suggested. Many local permaculture groups have already demonstrated the success of low-input high output agricultural techniques in the region, such as companion planting and Systems of Rice Intensification (SRI), efforts that are certainly replicable (Gurung *et al.* 2001; Himalayan Permaculture Group 2006). It is time for organizations like the WFP and the government of Nepal's institutions attached to the Ministries of Agriculture and Development to take these initiatives more seriously, and begin to move away from a reliance on food aid in Karnali.

It seems reasonable to also move from assuming that food aid is *necessarily* helpful to giving just as much credence to the opposite assumption (Lappè, Collins, and Kinley 1999: 188). Indeed, this skepticism is justified, since there is limited evidence that food aid—particularly programs like Food-For-Work and other non-emergency food aid programs—have delivered

any, long-term nutritional gains to those it targets (Maxwell and Barrett 2005; Marchione and Messer 2010; Poh 1999: 199), while often having the additional side effect of disproportionately benefiting the already well-off (Lappè *et al.* 1998: 135). Further, addressing hunger requires ‘not so much the transfer of food as the transfer of power,’ as food studies scholars have rightly pointed out (George 1976: 206-13, cited in Pottier 1999: 148; Mares 2010). Simply providing food in the short-term does not address the corresponding rights that promote and sustain overall health and wellbeing in the long-term. As leading food aid scholars have asserted, the right to be given food is fairly meaningless without other basic human rights to health, agriculture, education, and the right to a productive livelihood (Barrett and Maxwell 2005: 113; Dréze and Sen 1989; Marchione and Messer 2010: 17; Sen 1981, 1999).

Therefore, dwelling on food aid as *the* way to mitigate hunger, or even focusing too much on how much and what criteria should be used in its delivery—diverts attention from the factors that create hunger, which are historical and political economic in nature, and often enshrined in policy. As Teresa Mares and Alison Alkon (2011) propose, we must move beyond discussions of just guaranteeing access to food and bring to the table the fundamental inequalities related to land distribution, control over other livelihood resources, and entitlements that are continuously being reconfigured. These are the ‘bread and butter politics’ (Watts 2000) that we should be talking about. This discussion is ultimately about food sovereignty, self-determined futures, and hopes for improved livelihoods. If there ever was a time to put our ears to the ground, and listen to local farmers for guidance, it is now. Their experiences and knowledges should be brought to bear on the process of creating more justice-oriented food policies in Nepal, and in determining the appropriate responses to food shortages and experiences of hunger. This way, communities can determine their own sources of ample, nutritious foods, and less people will have to walk great distances to stand in line waiting for food to fall out of the sky.

### **Rethinking “Better than Nothing”: A New Bread and Butter Politics in the Age of Short-Term Care**

*Institutionalizing soup kitchens leads people to expect that inevitably there will be people without enough to eat; establishing permanent homeless shelters leads people to think that it is normal for there not to be enough affordable housing.*

~ Paul Kivel, *Social Service or Social Change?* 2007

*And we have the audacity to ask whether doing something is always better than nothing. Saying no is certainly an option. We say no all the time.*

~ Linda Polman, *The Crisis Caravan*, 2010

My goal throughout this dissertation has been to foreground the voices and experiences of those who participate in, and are meant to benefit from, short-term models of care in Humla. As the narratives of Humli people demonstrate, experiences of health and hunger are inextricable, and strategies to obtain health camp medicines and bags of subsidized food aid rice are inextricably bound up in protracted daily struggles with poverty, scarcity, and subsistence. Collectively, my findings reveal the resilience of Humlis who live in the global margins, and the complex ways that “caring” in the short-term can structure in limiting ways the long-term hopes and needs of communities, and the way these needs are met. These findings also highlight a crucial need to rethink the contemporary models of short-term care that prevail as global health, development, and humanitarian programs in settings of structural violence, and where people’s basic material and non-material needs are not met.

To do so, we must reexamine the social lives of representations that characterize out-of-the-way places like Humla as “beautiful and poor” and inhabited by “sick and starving” people who are always “on the brink of famine” or in a suspended state of “food crisis.” The interventions that appear around these claims and representations of place and suffering are often perpetuated as being “better than nothing.” Should we not first and foremost be focusing our attention on addressing the “nothing”—a lack of basic healthcare, chronic hunger, impoverished hopes and dreams—against which the continuous use of episodic interventions of care are justified? We must rethink this idea of “better than nothing” and the interventions buoyant on its uncritical premise.

As Redfield (2005: 329) points out, humanitarian responses to human suffering cannot escape the historical conditions to which they respond. It is, then, crucial to examine the growth of medical volunteer programs, health camps, and food aid programs in a particular historical context. We must ask: Do these models of short-term care improve health, address hunger, or foster hope for improved livelihoods? In light of the decade-long conflict and the path of poverty

and hunger it exacerbated, prevailing models of short-term care seem to be a continuation of plans made in place of those aimed at meeting the long-overlooked basic material and nonmaterial needs of the Nepali people. We know these needs. In the material category we must include ample, self-determined food sources, clean water, education, employment, and basic health care, in this order. Non-material resources necessarily include dignity, respect, and hope. It seems, then, that it is long overdue for a dramatic change in policy focus away from short-term models of care that ‘tinker’ without addressing the larger determinants of health, hunger, and wellbeing; which, when met, might creating the conditions in which Humli people can take control of their own life chances and livelihoods.

I continue to return to the words of Bajjir Bishwa Karma, a farmer and father of five living in southern Humla, whose words serve as an invocation to the entire dissertation:

Foreigner organizations come to help because here we are poor...we have nothing here, look around...But, I think that if there were no organizations it would be better, because up until now they have not brought *bikās* [development]...Helicopters come and the *Thulo mānchhe* [“big people”] on the committees of the organizations in the district headquarters eat the money, they eat the majority of the cow, and the fine stream of milk flowing out of the teats, we are all left to fight for this. Is there hope in this?

His comments are wrenching and poignant, and they explode the idea of “better than nothing.” They point to the nuanced and ambiguous ways that Humli people experience and interact with the efforts of outside groups trying to ‘do good,’ but they also point to the new kinds of inequalities that are perceived as a result of these efforts. Perhaps the idea of inequality doesn’t really cover it. Ferguson’s (2006) concept of “abjection”—the simultaneous and increasing awareness of a privileged world that remains forever out of reach—is a good framework. Yet, it, too, falls short of getting at the affect that emerges when, for example, Humli’s speak of “*tension bhayo*” while deciding over medicines at a health camp or while waiting in line for food aid rice, fretful that it will run out, or that they will be beaten with a club for ‘stepping out of line.’ This local generative metaphor—along with other commonly heard phrases like “*Ke garne?*” (Nepali: What to do?) or “*Ke bhannu?*” (Nepali: What to say?)—also index the differing shades and feelings of disconnection, unfavorable tastes, and impoverished hopes that emerge so saliently in conversations about short-term models of care. It is evident in the lingering feeling that, even as Humli people know better than anyone else that medical volunteer programs, health camps, and

food aid programs are not “better than nothing,” that they may just be the best they’ll get to see. A new bread and butter politics must conceive of this idea as a terribly pernicious afterlife of short-term care, and seek to foster the conditions in which healthy and hunger-free lives are inextricable from one another, and mutually constitutive of hope. It must see the institutionalization of fleeting health camps, foreign medical personnel, and episodic food aid distribution as unacceptable.

And, here we must return to the idea of “signing up for the long haul,” and what that means to foreign actors and agencies that seek to help or ‘do good’ in Nepal or elsewhere. It seems clear that, first and foremost, the host country and local institutions must guide these efforts. The long haul, then, involves working to strengthen national health care systems, not disrupt, burden, or fragment them. Ultimately, at stake are issues of sovereignty, where a growing nongovernmental government threatens to subsume the powers of a state that—though still seeking a path to a more inclusive polity, and rather thin in places like Humla—must find its own way, goaded and driven by the voices and struggles of the Nepali people. Tinkering with short-term interventions cannot replace these larger political project.

The potential long-term impacts of ephemeral interventions of care merit further consideration and collaboration. While the use of more interpretative and “inter-subjective” qualitative data is often rejected as non-generalizable—and therefore insufficient to inform policy (Harper 2006: 65; see also Justice 1986: 135)—evaluations of the impacts and appropriateness of models of intervention will benefit from more nuanced understandings of the specific conditions in which they are conducted, as well as the social, political, and material traces and afterlives of their presence. As I have argued throughout this dissertation, we must rethink the appropriate reasons, guidelines, and boundaries for the provision of care—especially in the short-term—to people living in conditions that do not promote health, and where hunger is so commonly felt and feared. The experiences, knowledges, and practices of those intended to benefit from these programs must also be brought to the planning table; their claims and critiques centered in policy discussions, heard more loudly than those who have historically spoken on their behalf. They are the real “stakeholders”—those who have the most *at stake*—in global health, development and humanitarian projects. But, let the necessary plans to provide prudent medical care or humanitarian relief to populations in need not supplant concerted efforts to make these measures no longer necessary.

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## APPENDICES

### APPENDIX A: *Glossary of Nepali Terms and Phrases*

#### Nepali

#### English

<i>Amchi</i>	Practitioners of Tibetan medicine
<i>Āphno mānchhe</i>	‘One’s own people’
<i>Baksi/Baksha</i>	Witch/sorcerer
<i>Bato hālnu</i>	The practice by <i>dhāmi</i> of applying a burning stick to flesh in order to exorcise malevolent spirits
<i>Besā hālnu</i>	Working for neighbors in exchange for grain, cash, or land use
<i>Bhāt</i>	Cooked rice
<i>Bhok</i>	Hunger
<i>Bhokmāri</i>	Famine
<i>Bhotiya/Bhotey</i>	the phrase used to refer to Tibetan speaking ethnic groups in the mountains of Nepal
<i>Bhut</i>	Ghost
<i>Bideshi</i>	Foreigner
<i>Bikās</i>	Development
<i>Bishwā khāddhya</i>	‘World Food,’ used colloquially in Humla to refer to the WFP
<i>Biswās</i>	Trust; faith; belief
<i>Chakari</i>	A social institution of currying favor from friends and family in positions of power, adapted into secular life from the ritual Hindu practice of obeisance
<i>Chāmal</i>	Uncooked rice
<i>Chāng</i>	Tibetan, home-brewed ‘rice beer’
<i>Chiyā</i>	Sweet, milk tea
<i>Dāl bhāt</i>	A staple meal of rice, lentils, and typically a Vegetable like <i>sāg</i> (spinach) or <i>alū</i> (potato)
<i>Dhāmi</i>	Oracular healer; shaman
<i>Dhārma</i>	One’s cosmologically ordained duty
<i>Dhoko</i>	A strong bell-shaped baskets woven from lattice bamboo
<i>Dum</i>	‘Untouchable’ caste
<i>Gābri</i>	A wooden tool for pounding grains and beans
<i>Godām</i>	Nepal Food Corporation (NFC) food depot
<i>Gorkhe lauri</i>	A phrase meaning the ‘stick of the Gurkha,’ used still to refer to beatings with clubs by army, police
<i>JaDibuti</i>	Medicinal herbs, roots, flowers and plants
<i>Janā Āndolan</i>	People’s Movement [for Democracy] (1990)

<i>Janā Yuddha</i>	People's War (1996-2006)
<i>Jhāro</i>	A high-resin pine that burns slowly and brightly
<i>KakaD</i>	A local Humli tobacco
<i>kālapāni</i>	'Black water'
<i>Khāddhya</i>	'Food' but often used colloquially in Huma to refer to the Nepal Food Corporation (NFC) depot
<i>Khāddhya asurakshā</i>	Food insecurity
<i>Karnalivasi</i>	People who live in Karnali
<i>Kati tension bhayo!</i>	What tension!
<i>Katta</i>	A measurement (bag) of food aid rice; approximately 40kg
<i>Khāl</i>	Unit of measurement, approximately 20 kg.
<i>Kuire</i>	Slang for a 'white person'
<i>Lobhi</i>	Greedy
<i>Loktāntra Āndolan</i>	Democracy Movement (2 <sup>nd</sup> People's Movement, April 2006)
<i>Maobādi</i>	Maoist(s)
<i>MāRnu</i>	Shrine for worshipping the <i>Masta</i>
<i>(A)Matwāli</i>	(Non) Alcohol drinking
<i>Momo</i>	Tibetan dumplings
<i>Nāmlo</i>	A head strap used for carrying loads, made from strong fibers, such as jute
<i>Nānglo</i>	Woven lattice tray for sifting grains of rocks
<i>Nātabād</i>	Favoritism towards one's family members or relations
<i>Nayā Nepal</i>	New Nepal
<i>Pānchayāt</i>	A political system that elected administrative councils indirectly at the village level
<i>Parbātiyā/pahāDi</i>	'Of or belonging to the hills'
<i>Phāpar</i>	Buckwheat
<i>Phuru</i>	Carved wooden bowls used for eating and drinking
<i>Raksi</i>	Home-brewed grain alcohol
<i>SaNsthā</i>	[Foreigner] organization
<i>Samghiyatā</i>	Ethnic federalism
<i>Shishnu</i>	Wild stinging nettles
<i>Siphāris</i>	Literally, "recommendation"; a hand-written chit used for getting more food aid at the NFC depot
<i>Sulpā</i>	Chillum-like pipe for tobacco
<i>Swāsthyā shivir</i>	Health camp
<i>Thulo mānchhe</i>	'Big person'
<i>Ukān</i>	A proverb

## **APPENDIX B: *Recommendations for Medical Volunteers and Participating Programs***

### **“From the Horses Mouth”: Recommendations in Context**

One of the deliverable goals for my research was to produce a set of recommendations for future medical volunteers and organizations running volunteer programs. Drawing on the stories and experiences of medical volunteers and the local NGO and health care workers with whom they interacted, recommendations are contextualized here below briefly. I have divided the recommendations into three sections, based on the temporal sequencing in which I conducted the interviews: Preparation, Volunteering, and Leaving. A final list of recommendations is synthesized at the end of the discussion.

#### ***Preparation***

All medical volunteers discussed the need for prospective volunteers to research organizations and programs before selecting one, and to carefully consider if a short-term medical volunteer trip is appropriate. Personal traits identified by medical volunteers and the Nepalis with whom they worked as important for successful short-term medical work in poor areas include being flexible, “able to find humor in unfunny situations,” sensitive to other cultures, creative, able to go with the flow, patient, kind, caring, strong, thick-skinned, and “not afraid of insects and dark holes.” Several volunteer doctors suggested a course in tropical medicine as appropriate preparation because it focuses on afflictions that remain prevalent in poor countries while also confronts the challenges of working with mid-level health care providers and resource management in low-income settings. “If it were my health program,” one volunteer said, “I would say that this is a requirement.”

In selecting an organization or project, volunteers commonly identified several key programmatic characteristics. These include transparent use of volunteer fees (if applicable); clear, realistic and time-bound project goals and tasks that match volunteer needs, specializations, and the self-identified needs of the communities hosting the program; evidence of collaboration—preferably long-term—and reciprocity with public health care sector and/or other medical volunteer programs in the area; appropriate logistical and ground support

throughout the volunteer stint, including staff for translation; and a sense of rapport and reciprocity with local communities.

Volunteers spoke consistently of a need for organizations to provide ample and accurate information to prospective volunteers. This will help NGOs select qualified volunteers whose personal goals align with those of the organization, as well as assist medical volunteers in deciding if the location and kind of volunteer project is appropriate. Some key suggestions provided by both volunteers and NGO directors and program coordinators include: putting previous and prospective volunteers in touch; providing recommended reading lists that include diverse disciplinary perspectives on short-term volunteering and the ethics of international engagement, information on area relevant socio-demographic and health parameters, and previous volunteer reports. A careful cultural orientation about the destination area was another recommendation made by many volunteers.

I didn't expect there to be so much disarray...The organization had no plan, and in terms of work, there's no structure to what they do. They just let us volunteers loose in [the villages]. (British medical doctor)

You cannot prepare for everything...but [NGOs] need to be more specific on the website, and the information for volunteers. 'This is what you should expect, you should be prepared for this.' It might reduce the number of volunteers, but then the right people might choose to come. It's better to have few volunteers who can cope with the stay...It's just so sad that they don't put former volunteers in touch with new ones, so that we can hear it from the horses mouth. (Dutch nurse)

Participants stressed conducting thorough research on the host country's medical and health care laws and protocols well in advance before leaving to volunteer. After determining that one is legally allowed to engage in the intended volunteer work, volunteers should prepare and bring copies of passports and home country licensures, as well as complete paperwork required by visiting countries' ethics committees and regulatory councils. In the case of Nepal, this might include the Nepal Health and Research Council (NHRC), the Social Welfare Council (SWC), and the Nepal Medical Council (NMC). If medical volunteers are intending to work at host country health care facilities, appropriate letters of permission and intent should be submitted and approved before volunteer work commences.

Language was cited as one of the greatest barriers to achieving organizational and personal goals for volunteers and local health care workers. Nepali villagers and volunteers also expressed

a strong desire to be able to communicate directly with one another. A report submitted by two medical doctors to their host NGO captures the comments and recommendations of many participants.

It should be suggested to future volunteers that a course in basic Nepali would be highly beneficial before coming out to work in the area. In addition, if funds allow, it would benefit [local health care workers] to undertake English courses prior to any future training from English-speaking volunteers. This language barrier severely limited our methods of training and testing. How could it not?

Many volunteers stressed a need to “consider the local conditions” before embarking on short-term medical engagements, such as conducting research on the history, prevalent health issues and disease burdens, systems of healing, geography, food, economy, and culture of the country and, if available, specific region where volunteers will live or work. This includes understanding specific living circumstances of intended volunteer sites.

### ***While volunteering***

Volunteers discussed the need for medical volunteers to “listen first, [and] try to gain an understanding about what is really going on in the places we are trying to help.” Several suggested volunteers focus on public health issues and problems that are not medical in nature, such as health education awareness, safety, indoor air quality, microcredit, hygiene, water, food and nutrition, education, perinatal care, safe motherhood and women’s empowerment.

As discussed, all medical volunteers strongly recommended restraint in the distribution of medicines when they are not needed. Interviews and participant observation revealed how difficult this was, but in interviewing around recommendations for future volunteers, responses stressed the need to discourage the practice of simply giving medicine because it is the norm.

Many participants discussed the need to show respect and deference toward local health care workers, especially when working alongside them in facilities and community settings. Respondents suggested that this attitude also be extended towards the Nepali people with whom they interact, practicing “humility towards tradition, habits and decision” in clinical facilities, villages, and homes. Two volunteers admitted that this “was hard to do [when] people brought their children into the clinic with toothpaste and cow shit in their wounds.”

## *Leaving*

Several volunteers discussed wanting to provide input and recommendations for organizations and future volunteers. One participant told me during preparation to return home:

Many volunteers recommended exit interviews with organizational staff as an important component for NGOs, and some discussed frustration at not being asked for input or receiving any feedback on reports submitted after volunteering.

It was just the most upsetting, distressing experience I've had in working overseas, and, all I could do was describe [it] in a report...But, I don't know where it went. Certainly nobody commented on it afterwards...No feedback or anything...It's so frustrating because you've been there and you have a bit of experience, and then at the end of the day it doesn't make any difference. (British medical doctor)

Several medical volunteers suggested compiling a file of volunteer reports and notes on exit interviews, which could help establish a system to monitor and evaluate short-term medical volunteer outcomes on the communities, the coordinating organizations, and the national health system over time. One participant noted,

If the communication is good you can establish some continuity in these programs...so you're not crossing over, starting over or repeating work that's already been done out here...For example, I had not a clue as to what the doctors and volunteers before me did, and whether or not I am saying the same things. (Austrian nurse)

Perhaps most significantly, many volunteers spoke of a need to establish a system for regulating short-term medical volunteer work; not only in Nepal, but also on a larger level. In fact, there was large interest in the creation of an International Medical Volunteer Code of Conduct, though many volunteers and Nepali health care and NGO workers also noted that the breadth and scope of kinds of short-term medical volunteer programs might make regulation difficult. Still, as Luke told me towards the end of his stay in Humla: "Something must be done...We can't all be out here willy-nilly trying to save the world, alone...So many people have done what I'm doing right now, and I have no way to learn from their experiences and their mistakes. What a shame."

I didn't know how isolated I'd be, from a communication point of view...I just didn't imagine that I'd be living in a spider den on a roof, climbing a ladder to pee, flashlights or candles to walk after the sun went down, people so desperately in need of so much...coming to someplace that is literally in the middle of nowhere and constantly on the brink of famine...I just didn't think about any of this before coming.

A Dutch nurse told me the following:

I have not been convinced that it is a good idea to come as a volunteer, and I wish I could tell that to other people thinking about coming to do this work.

\* \* \*

The recommendations presented below are synthesized from participant responses and, in part, draw on my own experiences and observations. While it is not an exhaustive list, it grounds the discussion of short-term medical volunteer work in ethics and impacts that extend beyond purely curative frames. These recommendations are also intended to disrupt the often inappropriate binary of humanitarian help vs. harm— notions that are often incommensurable, unfixed, and embedded in different cultural or medical systems. Lastly, they force us to consider the straddling of accountabilities while also critically examining, and weighing, the limits and possibilities of our desire to 'do good' abroad.

### ***Recommendations for Medical Volunteers***

1. Decide if short-term volunteer work is right for you. This is the most important decision for individuals to make.
2. Before going, understand the contexts of the host country, including: histories of colonialism, war, and structural violence; national and regional political economies; agricultural patterns and changing foodways; local ethnomedical systems; and relevant socio-demographic and health parameters.
3. Do your best to learn the local language(s).
4. Consider local needs first. Look for volunteer opportunities involved in nonmedical projects linked to better health outcomes, such as those that seek to improve access to clean water, address local food demands and needs, and bolster educational environments, especially for young girls and women.

5. Research the participating organization. Understand clearly its reputation and its linkages with other governmental and nongovernmental institutions in the region.
6. Know in detail the nature of the work you will be doing. Communicating with previous volunteers is an important starting point.
7. Consider the ethics of the work you will be doing, and do not engage in surgeries without follow-up care or needless and avoidable medicine distribution.
8. Critically evaluate the potential impacts of the work, both positive and negative – for yourself, the national and local health care systems, ideas about health and medical care, and the dynamics of recipient communities. Do not create or perpetuate inequities.
9. Think about what you will leave behind and what you will bring home.

### ***Recommendations for Participating Organizations***

1. Think clearly of an organizational mission. Does it foster social service or work for social change? Try to be an organization that does the latter.
2. Present transparent programs, providing accurate information for prospective medical volunteers/students, including reports from previous participants.
3. Create realistic and measurable goals for medical volunteers.
4. Select volunteers with proper credentials, as well as those with characteristics appropriate for short-term medical work in low-income countries, such as cultural sensitivity and humility, self-awareness, humor, flexibility, patience, and creativity.
5. Register all medical volunteers and programs with relevant host country councils and ministries. Adhere strictly to their codes of conduct and ethical guidelines.
6. Work in accordance with priorities set out by the host country health ministry.
7. Match volunteer skills and specializations with articulated needs of the community.
8. Give volunteers thorough orientation before engaging in work.
9. Make every effort possible to collaborate with other medical volunteer programs, and defer to local health care institutions.
10. Prepare plans with input from local institutions and communities for evaluating volunteer program impacts to ensure the work does not duplicate, disrupt, burden, or fragment existing local health care delivery.

- 11.** Provide strong logistical support for volunteers on the ground, including translators when needed. Keep current language materials available in organizational offices and work sites.
- 12.** Create a system for monitoring and evaluating volunteer work. Conduct exit interviews and compile volunteer reports. Research designs involving mixed methods will also contribute to iterative and critical reflection on goals and achievements of short-term medical work. Make this information freely available on the Internet.