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# Necropolitics in the “Compassionate” City: Care/Brutality in San Francisco

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## ABSTRACT

In San Francisco in the United States, the urban precariat is governed simultaneously by two logics of intervention that are highly contradictory: compassion and brutality. In this article, I explore the contours of violence embedded in humanitarian governance for unstably housed/homeless women who use drugs as they navigate care systems for their health and well-being. I use Mbembe’s concept of necropolitics to examine how women embody an *anticipation* of death, at the same time as they manage their risk for *actual* death in engagements with care in a city paradoxically known for its progressive, compassionate principles of intervention for those who are most marginalized.

## KEYWORDS

United States of America;  
care; drug use; governance;  
healthcare; necropolitics

### *The Prayer of Saint Francis of Assisi*

Lord, make me an instrument of your peace;  
Where there is hatred, let me sow love;  
Where there is injury, pardon;  
Where there is doubt, faith;  
Where there is despair, hope;  
Where there is darkness, light;  
And where there is sadness, joy.  
O Divine Master, grant that I may not so much be consoled as to console;  
To be understood, as to understand;  
To be loved, as to love;  
For it is in giving that we receive; it is in pardoning that we are pardoned ...  
And it is in dying that we are born to eternal life.

During my ethnographic field work in San Francisco, California – a place perceived as having one of the most progressive health care safety nets in the United States – I discovered early how the city operates as a biopolitical gray zone (Bourgois and Schonberg 2009; Levi 2004), where the urban precariat is governed simultaneously by two prevailing logics of intervention that are also highly contradictory: compassion and brutality. The city is the namesake of Saint Francis of Assisi, a figure whose sainthood is premised on the notion that social outcasts should be embraced, humanized and bestowed compassion. Saint Francis conferred compassion on those who suffered from poverty or disease and people who were socially excluded because of so-called moral transgressions. He was rumored to have been buried on the “Hill of Hell” – the name given to a local burial ground for thieves, murderers and lepers – in a final symbolic act demonstrating compassion through proximity to those who suffered social exclusion (Murray 2008).

Saint Francis’ story is an allegorical roadmap to examine the city of San Francisco as a local moral world (Kleinman 1992), where a politics of compassion is sometimes publicly evoked about the most socially vulnerable, but where the provision of care is co-articulated with a politics of death. In this

article, I draw on long-term ethnographic fieldwork with women in San Francisco who are unstably housed or homeless, managing addiction and chronic illness, and who seek help from what I call a local “care assemblage,” an ethnographically-generated concept I use to characterize the local care system through which women address chronic health issues, mental illness and trauma, homelessness and addiction. Women navigate this assemblage strategically in their daily survival in the streets and in housing of last resort such as residential hotels. In their pursuit of care, women are subject to forms of violence or corporeal suffering and live in a subjective state anticipating death, despite the tireless efforts of many frontline workers to mitigate these harms through low-threshold drop-in centers and street-based interventions.

Angela Garcia has explored the paradoxes of pain and recovery, violence and care, conceiving these as “processes coexisting in the life of drug users” (2014:51), but she does so in contexts characterized as low-resourced (Garcia 2014, 2015; Garcia and Anderson 2016). In this article, I am concerned with exploring the dynamic between compassion and punishment in a context that is arguably “as good as it gets” with respect to a US health care safety net. I explore the contours of violence that women experience in seemingly mundane interactions with social and medical institutions. In this context, while women can access a relatively robust safety net, the broader configurations of care, coupled with the mediating punitive ideologies directed at people who are poor and experiencing addiction, result in women’s care experiences taking place alongside undercurrent forms of brutality. I use Mbembe’s (2003) concept of necropolitics to examine how women chronically *anticipate death* at the same time as they manage their risk for *actual* death in engagements with care. Thus, I pursue the broader ontological question posed by Mbembe: “What place is given to life, death, and the human body (in particular the wounded or the slain body)” (2003:12) among women who are homeless, using drugs, and managing compounded health issues in the context of the so-called “compassionate city?”

## Assembling care for the marginalized

Anthropologists have built an extensive body of scholarship examining emergent forms of care that are a result of a “post-welfare” neoliberal era. The scholarship spans many domains, so I will outline a selection particularly influential on this analysis. Many have characterized the existence of a “new regime” of poverty, after approximately 40 years of global neoliberal reconfigurations which includes: 1) the retrenchment of federal intervention into poverty in the US (Goode and Maskovsky 2001); 2) a demonization of poverty globally (Biehl 2004; Hansen et al. 2014); and: 3) the ascension of the penal state or punitive logics as primary modes of governing the poor (Auyero 2012; Wacquant 2009). Many ponder: How is care delivered to the most structurally vulnerable (Quesada et al. 2011) in a “post-welfare” moment and what intimate negotiations of care emerge in its place? Care is now often configured as a patchwork of services that function to address the everyday crises of contemporary poverty. What Sangaramoorthy (2018:488) calls “band-aid care” has become the new norm.

Earlier studies have examined how people experiencing homelessness or housing instability survived by continuous movement through an “institutional circuit” of hospitals, shelters, jail and the streets (Hopper et al. 1997). Marginalized people develop a savvy expertise in these circuits in order to mitigate exposure to violence in the streets and shelters (Luhmann 2008:19). Further, countless ethnographies have traced the urban precariat’s interaction with social welfare, medical, and penal institutions (Auyero 2012; Knight 2015; Sufrin 2017; Ticktin 2011); their experiences of social abandonment (Biehl 2013); their entrenchment in “structurally imposed precarity” (Das 2015; Fassin 2005; Wacquant 2009, 2014), and enactment of structural violence (Farmer 2003; Thomas 2011). These researchers among others demonstrate how long-term ethnography captures the nuances of exclusion, harm and processes of stigmatization in relationship to conditions, including HIV (Farmer 2003; Sangaramoorthy 2014), addiction (Bourgois and Schonberg 2009; Knight 2015), and racialized conditions constructed as pollution risks to the social body, such as cholera (Briggs 2003).

An ongoing theme in this literature is that harmful contradictions manifest when vulnerable populations engage with institutional structures. Garcia has noted that forms of care enacted among

marginalized subjects experiencing addiction are defined by the tensions between “vice and virtue” and “injury and care” (Garcia 2014, 2015; Garcia and Anderson 2016). Specifically, for the urban precariat, violence and care are always deeply intertwined (Garcia 2015:456). This tension is a defining characteristic of the moral worlds and lived experiences of marginalized people (Garcia 2014:51).

Ticktin (2011) theorizes “regimes of care” among people seeking asylum in France. In this system, the “sick” and traumatized are deemed “deserving” of asylum, while people who are “just poor” are marked “undeserving.” In this hierarchy of deservingness, a suffering body is deemed worthy of asylum only if it can be linked to a biomedicalized condition that is rendered deserving – for example, cancer. Others are subject to discriminatory narratives and active exclusion. Ticktin (2011: 4) draws on Fassin’s (2005) concept of “biolegitimacy” to theorize the creation of “morally legitimate suffering bodies” whose bodily integrity is determined by broader moral parameters of transnational regimes of care. This complex process of constructing deservingness relative to poverty, medicalization, and the state has been examined extensively in recent ethnographic work (Biehl 2004; Hansen et al. 2014; Knight 2015; Lopez et al. 2018b).

Two recent ethnographies engage with the paradoxes of care among unstably housed and homeless women who use drugs in San Francisco. Knight’s (2015:31) study of pregnant women who use drugs traces how women are made into “biopolitical projects” subject to a myriad of social and legal interventions that include care and coercion. Knight acutely traces the overt “moral adjudication” (2015:12) that pregnant women experiencing addiction face when labeled “failed mothers.” This adjudication is traumatic and is instrumental in women’s decision to delay seeking health care until a point of extreme urgency. Sufrin (2017), in her unique position as a physician/anthropologist, places herself within an explicitly punitive institution – a county jail – to examine “the emerging equivalence between the carceral net and the safety net” (2017:5). She traces the ambiguity of women’s subject positions as patient and prisoner when the jail may be the only site where women are able to access health care. She argues that here, care is fundamentally “ambivalent,” with a “mutual coexistence of the violence of punitive discipline with the concern and attention of caregiving” (Sufrin 2017:233).

Informed by this body of anthropological literature, I have developed an ethnographically-generated framework that captures the paradoxical governance of people who use drugs in my research context. This framework accounts for the unique subjective experiences faced by such highly stigmatized women. I argue that care for this population is configured in an assemblage which results in multiple experiences of violence and harm. I also argue that people who use drugs are marked as “undeserving” through both subtle and explicit institutional mechanisms. Consequently, they are forced to confront death and the prolonged anticipation of death even in their engagements with care.

The concept of assemblage has been used by various social theorists to analyze systems whose components are comprised of always-emergent social conditions (Marcus and Saka 2006). Central is the notion of “ontogenesis” – that subjects and social conditions come into “being” and are assembled so that “particular contexts and/or subjectivities actually hold together in experience” (Duff 2016: 17). Zigon uses the concept to analyze the global drug war, for instance, as a social phenomenon that defies totalizing categorization, but the diverse components of which impact intimate “ways of being-in-the-world” (2018:502). Drawing from these scholars, I conceive of unstably housed and homeless women who use drugs in San Francisco as navigating a care assemblage. I define a care assemblage as a configuration of care “whose properties emerge from the interaction between parts” (DeLanda 2006:5), but that is defined by fragmentation, heterogeneity and potential ephemerality (Marcus and Saka 2006). But there is an important nuance to this configuration – the role of death and dying in women’s engagements with care.

It should be delineated that women are negotiating a *necropolitical care assemblage* – that is, a configuration of care where confronting death or dying was a problematic leverage point for their survival. In his initial rendering of necropolitics, Mbembe characterizes Foucault’s biopower/biopolitics as “insufficient to account for contemporary forms of subjugation” (2003: 12). Whereas Foucault initially defined biopolitics as “a power that has taken control of both the body and life or ... life in general”

(2003:253), Mbembe poses the question of “under what practical conditions is the right to kill, to allow to live, or to expose to death exercised?” (2003:12). Mbembe suggests that for some, “weapons are deployed” to create “death-worlds ... conferring upon them the status of the *living dead*” (2003:40). Mbembe’s original conception was meant as an intervention into biopolitics to account for the bodily suffering and death among people living under conditions of exceptional violence – totalitarianism, war, extermination camps, and the physical brutalities of slavery and colonial rule. I use the concept of necropolitics here to examine how the governance of highly marginalized people who use drugs incorporates a politics of death, whereby women’s bodies are subjected to prolonged bodily suffering along their life course. Within the so-called compassionate city of San Francisco, this politics of death is often embedded and diffused in implicit ways across a care assemblage. As I will demonstrate, the politics of death in this context is intimately intertwined with humanitarian governance – that is, women have to suffer in order to get “saved” by the care assemblage.

### Methods: fieldwork in the “compassionate” city

I spent nearly two decades in San Francisco, working with unstably housed women who use drugs. Initially, I was an outreach worker and facilitator in a program for women who were court-mandated to drug treatment after release from jail. I worked at a residential hotel-based outreach team that targeted women who use drugs, at a syringe exchange serving people experiencing homelessness, and in over a dozen mixed-methods studies with people who use drugs in the city’s Mission and Tenderloin neighborhoods. I was embedded professionally and personally in the city’s care assemblage with some of the most awe-inspiring front-line providers, who are global leaders in providing services to people who use drugs – primary care clinicians, case managers, outreach workers, harm reduction program coordinators, and overdose prevention program leaders. Women met with these providers on a daily basis in shelters, residential hotels, urgent care clinics, neighborhood drop-in centers and emergency rooms. My analysis is not meant to minimize their daily efforts to keep people alive in the face of insurmountable structural violence. Instead, it is an attempt to explore the broader dynamic where arguably the most robust safety net for marginalized populations in the US is entwined with intense suffering on the part of those who are marginalized, and to identify the deep, affective implications of this care configuration.

San Francisco once existed in the national imagination as the bastion of progressive politics and a countercultural sanctuary. This was rooted in the sexual freedom and drug experimentation of the 1960s, the LGBTQ rights movements, and HIV/AIDS activism which started in the 1980s and remains to this day. San Francisco is also a leader in providing HIV care to marginalized populations, it is a pioneer in progressive approaches to health care and housing-first initiatives, and it has progressive policies regarding syringe access and overdose prevention programs. But one fundamental nuance must be situated historically: the care assemblage is empirically distinct from a robust social welfare system. The care assemblage operates in an emergency response-mode to the everyday crises ushered in by what Harvey calls “the creative destruction of the welfare state” (2005:3, 2007). The construction of San Francisco’s care assemblage was accomplished through grassroots activism focused on the delivery of services to people in urgent, life or death need because of failed social policies and the rollout of the “War on Drugs.” This is the legacy of Saint Francis come to life through service to the socially abandoned, criminalized or confined. Though some aspects of this network have been institutionalized, because of the complex needs of the urban precariat and a lack of investment at federal and state levels, the system exists in an assemblage form operating through ontogenesis (Duff 2014, 2016) – that is, by those at the front lines as they patch together services to intervene urgently for their clients. But an assemblage configuration – a manifestation of neoliberal health reform – also facilitates spaces where “falling through the cracks” results in acute physical and psychological suffering and prolonged proximity to death.

The acute suffering of people experiencing homelessness is always visible on San Francisco’s city streets. Ideological divisions about homelessness play out dramaturgically in media, at community townhalls and at neighborhood demonstrations. Two sentiments routinely battle each other. One

side critiques the continued municipal investment in services, alleging that there was no visible return on this investment and that services either fail in their missions or perpetuate reliance on the system. These narratives include claims that people who access services are overly entitled, a drain on resources, and the source of “quality of life” issues (e.g., public inebriation, public urination/defecation, and open drug use). These sentiments are typically rallied in order to justify destructive “sweeps” of homeless encampments and crackdowns on people gathering in public, and they fuel “not-in-my-backyard” ideologies that are actively punitive to community-based organizations. On the other hand, people advocate for increased services on the basis of public health obligation and evidence-based interventions for more low-threshold housing and harm reduction services, publicly accessible bathrooms, and drug treatment and mental health services.

During my fieldwork there was also a discursive thread embedded in a subset of the language addressing poverty – that of a humanitarian obligation to provide compassionate care to people who are suffering. Municipal leaders made several pronouncements, symbolically institutionalizing the notion of compassionate obligation in how the city conceives of and purports to intervene into issues of homelessness, street-based drug use, and mental health crises. In the early 2000s, the city released a comprehensive plan to address homelessness, drawing momentum from Housing First initiatives nationwide. In the *Ten Year Plan to Abolish Chronic Homelessness in San Francisco* (San Francisco Ten Year Planning Council 2004), policy makers appealed to the city’s legacy of compassionate governance by pronouncing: “We must have the courage to say that we will no longer tolerate, as the compassionate City of St. Francis, human beings living in abject misery and sleeping in our streets.” These public pronouncements were often received as a slap in the face by people actively subjected to the criminalization of homelessness as a matter of city policy in the form of sweeps of homeless encampments. This has accelerated in recent years with hyper-gentrification. The city government has been characterized as a master of “two-facedness” in its ability to profess compassion alongside the slash-and-burn treatment of homeless encampments (Graff 2018). Compassion is perceived, by many at the frontlines of drug use and homelessness, as nothing more than political performance.

In this moral milieu, women manage housing instability, chronic and acute health issues, and exposure to violence. For approximately two years between 2010 and 2012, I conducted initial ethnographic research with a cohort of 30 unstably housed women who used drugs, whose ages ranged from 19 to 55. I followed up as possible between 2013 and 2016. The bulk of my ethnographic work took place in the city’s Tenderloin and Mission Districts. I conducted ethnographic participant observation with women in residential hotels, at community-based service sites, in community clinics, at the county hospital, on street corners, on buses, in coffee shops or fast food restaurants, while running errands, and while strolling around the neighborhoods. I audio-recorded these interviews when appropriate and kept extensive field notes. I also conducted semi-structured interviews in private settings to construct women’s life histories and to allow them to reflect on certain events in their lives. The central question guiding my analysis in this article is: How does the tension between compassion and brutality play out in women’s everyday life worlds as they interface with the care assemblage?

## Results

Below, I present data in the form of two extensive ethnographic case studies. My reasoning is two-fold. First, these case studies illustrate the range of experiences that converge to create the necropolitical experiences for women. Second, I do so in order to be able to write about two women more extensively to understand the complexities of brutality within the care assemblage.



### ***Implicit brutalities: when care equals death***

When we met, Crystal was 45 years old and had recently been released from the county jail. She was thin, had graying hair which she kept cropped short, and a very tough demeanor. While in jail, she had strategically accessed a drug treatment program that, upon release, would facilitate her placement in a transitional housing program in the Tenderloin. Before this last period of incarceration, Crystal had been unstably housed and homeless for over 20 years.

Crystal was HIV positive and had a long history of drug use, including heroin and crack-cocaine. After being released from jail, she described herself as “clean and sober” and enrolled in a methadone program. This was hard to maintain, she explained, because in addition to the widespread availability of drugs in the neighborhood, there was an active drug economy in the hotel where she had been initially placed. Further, Crystal had debilitating chronic pain, which she partly attributed to a violent assault at the hands of correctional officers while incarcerated and partly to her time sleeping on the streets. Her pain often became so excruciating that self-medication beyond her methadone dose was the only way she felt able to function minimally.

Crystal lived life at a challenging biopolitical intersection between care and penalization. She accessed many health and social services to be sure – patching them together to sustain herself on little money and virtually no personal social support network. But she also did this in the context of extremely intertwined health and social service needs, extensive trauma and distress about past experiences of violence, while bearing the markings of a person who injects drugs on her body. Any time she entered a social service organization, clinic or walked down the street, she could potentially be questioned about or stigmatized for her drug use. She was routinely monitored on the streets by police in the Tenderloin. She conceived of herself as a sort of “wounded body,” physically bearing the markings of her history of trauma, while also embodying them in the form of excruciating chronic pain from police violence.

Crystal immediately alerted me to her savviness regarding how to perform various aspects of her identity to leverage deservingness within the care assemblage. When she interfaced with her methadone program or the needle exchange site, she performed a particular “addicted” subjectivity. When she accessed resources because of her HIV status, she performed a “sick” “biomedical subject.” When she accessed resources based on being unstably housed and/or having experienced trauma, she could embody being a “suffering subject.” And when she was stopped incessantly by police on the streets for “looking like a dope user,” she was instantly cast as a “penal subject,” which required obedience to avoid violence. These were all authentic, lived aspects of her identity, but they also signaled the expertise by which she came to navigate different logics of intervention within the care assemblage. These embodiments, appropriately performed, functioned to keep Crystal alive, granting her access to HIV medication, methadone, food and shelter.

When we met, Crystal was experiencing relative stability. She had access to temporary housing upon her release from jail. She had assistance in reestablishing HIV care and applying for Supplemental Security Income (SSI), a federally-funded disability program, on the basis of her HIV and disabling chronic pain. SSI is one of the last remaining federal resources available to highly vulnerable populations and is extremely important in navigating the broader care assemblage (Lopez et al. 2018b). SSI disability often facilitates access to housing slots, and its role among the urban precariat has been examined extensively (Hansen et al. 2014; Knight 2015; Lopez et al. 2018b). In particular, the program’s relationship to a “disability economy” (Knight 2015) is central to the everyday survival of women who use drugs. SSI functions as the glue that can carry marginalized people through sites of the care assemblage. A federal designation of disability not only provides a reliable monetary resource, but it also marks deservingness that tracks people materially in their electronic medical records across health and social service programs. For this reason, advocates often see SSI as an essential intervention to establish stability and access to care.

Understanding the symbolism of SSI from Crystal’s perspective and the anxiety it provoked was the most ethnographically evocative issue we navigated together. The application and disability

verification process for SSI is cumbersome (Lopez et al. 2018b). One has to use medical records and testaments from medical providers to validate that one's diagnoses are so severe and chronic as to be debilitating or to place one at high risk of death:

We may consider you “disabled” if you have a medically determinable physical or mental impairment (including an emotional or learning problem) which: results in the inability to do any substantial gainful activity; and can be expected to result in death; or has lasted or can be expected to last for a continuous period of not less than 12 months (Social Security Administration 2016).

When Crystal sat down to sign this application, affirming the severity of her ailments, I did not initially realize that she felt she had officially endorsed her own death sentence. Crystal's demeanor was always bristly and combative – a dynamic that was initially challenging in our interactions, but eventually settled into an ongoing biting banter that was comfortable for us both. But after her SSI application was submitted, I witnessed an intense depressive spiral that I only later recognized was part of a self-mourning process related to her perception of SSI as confirmation of her impending death. While waiting for a decision about SSI, she became increasingly annoyed by forced compliance with the rules of her transitional housing, including curfews and restrictions on visitors. She started smoking crack cocaine again and became obsessed with the anticipation of her death.

The simultaneous search for permanent housing was also exhausting and required constant appointments and applications. Crystal reflected that “I can't take more of this shit. My body can't take it anymore, you know?” After two weeks Crystal called me with the good news that she had secured a permanent room at the Frontside Hotel, a large residential hotel managed through a public/private program partnership in the Tenderloin. Happiness and excitement pierced through her depression as we pushed a cart of her few belongings through a bustling street in the Tenderloin one morning.

Crystal threw open her front door, but quickly deflated as she glanced around the room. As I tried to gather words of support, she intervened to analyze the tiny room with only a few feet of floor space and a case of “adult diapers” that program staff had propped on a shelf. “This *isn't* the kind of shit that was my *dream*,” she said. To have HIV and be living in places like *this*.” She had qualified for housing on the basis of her HIV, but that qualification also came with the reality of managing incontinence as a side effect of her new HIV medications. Crystal appreciated she no longer had to endure the miseries of sleeping on the streets, but the reality of the room struck her deeply. The room was tiny; its small window overlooked one of the most active drug corners in the neighborhood. Her depression and social isolation deepened.

When Crystal received notification that her SSI was approved, I offered congratulations and she told me woefully, “Yeah. But that's depressing too ... you only get it because you're sick.” While SSI represented some stability, it would still be challenging for Crystal to survive. After rent for her room, she would have approximately 580 USD per month to live on, in an expensive city, while managing chronic illness. Tragically, just a few weeks after settling in to the Frontside, the hotel caught fire and the tenants were displaced. With nowhere to go, Crystal slept in a cot in the lobby of another hotel, arranged by the Red Cross. This situation was particularly traumatic because it mirrored past experiences in jails where she feared assault. She hardly slept.

I encountered Crystal on the street one day, trying to hustle money from people in line at the check cashing storefront – a place where people without bank accounts can either cash checks or get advances on their checks for a substantial fee. I was shocked that her health appeared to have rapidly deteriorated. She now weighed less than a hundred pounds (45 kg), her cheeks were sunken, her skin was ashy, and her pants barely stayed up on her hips. She had totally disengaged from her methadone program and was now using heroin every day. She also was using crack extensively to stay awake, both to manage fear of assault at night and to stay awake during the day because she had nowhere to go. I probed about whether she had been in touch with case management about support. Case management, she felt, only approached her when they needed paperwork to keep her housing slot and she was hesitant to make contact. Because of the staff capacity at the various agencies where



Crystal accessed care, there were no built-in lines of communication to strategize across agencies. This is particularly frustrating for committed service providers. Staff capacity is highly strained in any case, but coordination across agencies is not funded and requires significant time and effort.

Crystal turned back to the SSI approval as the object of her frustration and sadness. We sat together one day as she sobbed: “You know, I thought it was going to take a while ... but they, they approved my SSI ... *immediately*. That just tells me there’s more going on ... than what’s being said ... You know, it’s a *good* thing, but it’s a *bad* thing,” she continued under her breath as she wept intensely:

If my body were breaking down, they wouldn’t even tell me because they couldn’t afford to take care of me. I mean, they [providers] wait until it’s *too late*, until your body’s *breaking down*. And then they try to give you treatment for the *last end* so that they don’t have to give it to you the *whole* time. Because it costs too much money ...

According to the SSA’s own definition of permanent disability, one does have to be at a “point of no return” in health status to be recategorized as disabled and receive benefits. Crystal was profoundly sad about having arrived at this point – a subjective space where she was afforded some stabilizing care, but only by proximity to her own death. Her afflictions had finally qualified for emergency intervention, but in what she felt were the last moments of her life. This invisible violence was salient to Crystal, angered her, and left her with a sense of abandonment and skepticism about how value was assigned to her life.

### ***Suffer to get saved: penalization within the care assemblage***

When we met, Lilah was 44 years old and a ten-year veteran of a local drug scene. She had been unstably housed for nearly two decades since losing her federally subsidized apartment, and since then, she had cycled between daily-rate residential hotels, shelters, and staying with friends or partners. Lilah had a long history of complex trauma, including prolonged childhood sexual abuse and three suicide attempts before the age of 18:

Nobody was malnourished [growing up], but there’s a lot of things – deep, heavy things – that went down. But we’re still living. So, I’m blessed. Even though I came through that way, I mean, I’m still *here* ... I’m still *here*. And God obviously has a plan for me because I *literally* tried to kill myself. I would have been *dead* three times! And I’m still *here*. He gave me a chance ... Obviously he doesn’t want me to go. He’s not going to let me go until he gets rid of me.

Lilah was a fierce person, both physically and emotionally, and was well-loved and feared by many. For this reason, I was shocked when she opened the door of her residential hotel room one evening, extremely despondent and looking emaciated. She was usually dressed snappily and appeared strong, but that day she was wearing baggy gray sweat pants and was shivering. She had been terminated from her methadone clinic because clinic staff accused her of a burglary in the neighboring building – an allegation she denied strongly. She was furious because she saw the accusation as part of her ongoing criminalization as a Black woman who uses drugs, but she was also in agonizing withdrawal from her regular methadone dose. She had been forced to purchase methadone pills on the street to relieve crippling chills, nausea, diarrhea and excruciating pain. She was totally immobilized in her cramped and unventilated room that she paid for by the day. She occasionally ventured down the hall to use the bathroom, which was shared with approximately 20 other people and was filthy. Our outreach team provided Lilah with a referral to another methadone clinic, but for several weeks after this encounter, no one saw her in the neighborhood.

One afternoon, I met Lilah at the busy bus stop outside of the county hospital where patients often smoke cigarettes and purchase drugs. She immediately launched into a story about how, since I had last seen her, she had gone into acute kidney failure and nearly died. She was undergoing daily dialysis treatment and invited me inside to join her for the procedure. We retreated to the clinic room, which was filled with homeless patients receiving dialysis. We both watched in fascination as

the technician hooked up Lilah's infusion port and started the machine which extracted her blood, cleansed it, and slowly pumped it back into her body. Lilah shared that after I last saw her, she felt increasingly ill, but mistakenly attributed all her symptoms to the miseries of opioid withdrawal.

For days, she had stewed in anger about termination from the methadone program. She had not been given an opportunity to defend herself – she was immediately marked as a criminal and terminated without a hearing. This criminalization played a role in her reluctance to reinitiate with another program because she was shamed and angered by the false accusation. Reluctant to face the same stigma if she went to urgent care, she self-medicated her withdrawal by purchasing pills illicitly. When the pills were no longer strong enough to manage her discomfort, she started injecting heroin again, which was available in her hotel.

Partially, because Lilah was so tough and self-sufficient, we did not push to plan for how she could reengage with a methadone clinic that evening. But there was also a moral dimension to why we did not intervene more actively. Lilah stood in front of us in excruciating pain, with vomiting and diarrhea, but acute opioid withdrawal is not automatically considered a health crisis worthy of acute medical intervention, such as a broken leg, even though the pain may be as severe or worse. Her indescribable pain and sickness were relegated to the realm of the “ordinary-extraordinary” (Bourdieu 1999) suffering of people who use drugs, a condition even we considered less exceptional in the context of frequent experiences with violence. The timing of her methadone withdrawal also masked symptoms of her kidney failure, growing in acuity every day.

Lilah developed a severe abscess in her neck from injecting; she self-treated this by lancing in her room. She then lost her room for failure to pay because she could not do sex work to make rent while she was so sick. She ended up on the streets. She recounted, “Now in the meantime, my legs and stuff are swollen. But I didn't know what it was ... I just figured maybe it's water [retention] or something ... I went to the shelter, checked in for that night. I was *sick*.” Shelter residents typically cannot be on site during the day and are forced to wander the city or find places to rest. Lilah was out on the streets and took a combination of illicit pills for her pain. She unintentionally blacked out and woke up in the emergency department after someone (she did not know who) had placed her on an involuntary psychiatric hold for erratic behavior on the street. After her 72-hour hold, she was released and directed to the methadone clinic located onsite. Feeling some relief from her withdrawal, she went to the nearby urgent care clinic to seek treatment for her swollen leg. They ran diagnostics, but the clinic was flooded with people that day. Lilah's anxiety began to mount because if she did not check back in at the shelter on time, she could automatically lose her bed. Fearing that punitive regulation, Lilah made the trip back to the shelter about 20 minutes away by bus and, utterly exhausted, did not return to the clinic for her test results.

The test results indicated that Lilah was in acute kidney failure and at extremely high risk of a heart attack, imminently near death, and needing to be admitted to the hospital immediately. But clinic staff could not reach her because she did not have a working telephone. Three days passed before the clinic finally located Lilah's mother through her emergency contact information and her mother drove 100 miles and scoured neighborhood streets until she found Lilah in a fast food restaurant. Lilah was quickly admitted and started dialysis.

As we sat together in the stuffy dialysis clinic, Lilah recounted how she heard from clinic staff that she was gravely ill:

[The clinician said] ‘Your kidneys have *failed*.’ I was in shock. My mouth flew [open] and I was like, ‘*what?*’ And she said it's to the point now, she said: ‘You might possibly be on dialysis. And I *don't* think there's a shot [at recovery].’ And this one doctor was sitting there, and I heard him say: ‘*What a waste.*’ I mean he didn't see me. He didn't know I was listening. But it hurt ...

Lilah's illness experience at the intersection of her opioid withdrawal and kidney failure are particularly evocative of how her health needs became enmeshed with the broader moralization of her addiction. As Raikhel and Garriot have suggested, her addiction – as a moralized and penalized condition – became part of a “trajectory of experience” (2013:8) that crosscut her

experiences within medical and social service institutions and impacted her biologically and socially. In managing her dismissal from the methadone clinic, withdrawal and kidney failure, Lila was negotiating subject positions of both a “diseased” and “criminal” body. Ironically, the suffering of withdrawal that she had endured had “allowed” time for her more “acceptable” condition to worsen to the point of obligatory emergency intervention. Lilah acknowledged the system failures related to her near death; however, she also recognized that at this point of acuity, a whole realm of more stabilizing resources would be triggered and become available. She framed this near-death experience as a blessing:

It was all a blessing, actually. So, by me getting kicked off of the [methadone] clinic and all that – probably if I wouldn’t have gotten kicked off, I probably would have *died* in the streets ... And that was a blessing.

Lilah anticipated a transformation of her positionality within the care assemblage – something extremely welcomed after weeks of pain. Her acute kidney failure would re-classify her from primarily being cast as an “addict” into an acute patient with a less stigmatized chronic illness. She would be routed through “more normal” channels of specialty care. This, she hoped, would eventually also lead to her official recategorization by the state as “disabled” with SSI, so increasing the likelihood of securing housing. Lilah unfortunately remained homeless and unstable for some time. She continued to have dialysis while staying in city-run shelters and occasionally sleeping nights on the streets. The port site where her dialysis was administered often became infected, as she had no way to wash regularly.

In spring 2015, I was walking in the neighborhood where Lilah spent most of her time. I came upon a makeshift altar and poster pasted on the street in front of a residential hotel announcing her memorial – Lilah had died of complications from kidney failure. I attended a small memorial service for her some weeks later and spent the afternoon with her family who shared stories about her ongoing struggles with drug use. They were, they said, grateful that, in death, she was finally no longer suffering.

## Discussion: the necropolitics of care

I want to return to the original questions that guided this analysis, related to the affective experience of women subjected simultaneously to both compassion and brutality, or to brutality as a gatekeeper or even penance for access to health and social interventions. The implications are both moral and practical: What drives this paradox and how do we intervene? If people must suffer to be saved even in San Francisco, is there any hope for less resource-rich and more socially conservative places to address the complex needs of the most marginalized populations, without also inadvertently inflicting harm? Both Crystal and Lilah navigated multiple systems critical to their survival, but the most life-sustaining interventions came when they were at death’s threshold and sick enough for the state to register them as “disabled.” This moral paradox illuminates the ways in which certain human lives are subjected to pain and suffering and at what costs. These were not exceptional moments of violence in their lives; rather, their narratives are examples of the prolonged everyday experiences of marginalized people who use drugs and the systems that govern them.

Fassin (2011) argues that moral sentiments such as compassion or benevolence should be a central object of anthropological inquiry, as these are often sentiments that guide intervention upon the most socially vulnerable. He points to a fundamental relationship between compassion and repression because both are about governance and the impact of power on subjugated or precarious lives (Fassin 2005, 2011). But he offers us a moral charge, which is to confront that the governance of the vulnerable meant to be a “relation of assistance” is also always a “relation of domination” (Fassin 2011:3). Compassionate interventions are typically deployed *upon* the precarious and rely on a firmly entrenched inequity between those with the power to intervene and those who are intervened *upon*. Women’s experiences highlight the contours of this violence and pain that circulate through a care assemblage.

The everyday violence that these women experience takes place within the coordinated efforts of the US War on Drugs, declared by President Nixon in 1971 and which has resulted in nearly 50 years of targeted policing, surveillance and criminalization (Cooper 2015; Netherland and Hansen 2016). These efforts have fostered dehumanization and racialized policing, but they have also resulted in deeply embedded moralizations and punitive frameworks that guide how institutions manage this population, even when they simultaneously promote care. The ideological common-sense approach to drug use for the last five decades has been one of criminalization, and modes of punishment become taken-for-granted mechanisms for “maintaining order” through disciplinary regimes subtly embedded in drug treatment modalities and in other controlling practices in care. These punitive mechanisms are part of a global war on drugs, which sets limits on political mobilization and the humanness of people who use drugs (Zigon 2018). The communities most impacted have long asserted that “the war on drugs is a war on people” (Zigon 2018) and the fallout from that war takes various nuanced forms such as the always-present proximity to death.

I find Mbembe’s concept of necropolitics a particularly apt way to characterize the suffering that women endure due to the War on Drugs punitive apparatus – a decades-long war that produces endless casualties and bodily suffering. Recent scholarship has adapted Mbembe’s concept of necropolitics to examine chronic forms of violence such as within the Mexican drug war (Wright 2011) and exposure to Anti-Blackness among Black mothers in the Americas (Smith 2016). This scholarship demonstrates how a politics of death becomes subtly embedded in institutional and cultural structures. I am engaging in a similar adaptation, while acknowledging the need to avoid conflating exceptional forms of state violence with the everyday violence and social suffering that I describe above. Nonetheless, as numerous scholars have argued, these forms of suffering exist along a continuum with exceptional violence and demonstrate how dehumanization and suffering are normalized and made legitimate in everyday practices (Bourgois and Scheper-Hughes 2002).

Mattingly suggests that the power of ethnographic narratives from the socially vulnerable lies in how they push us to examine “spaces of possibility” and “not only imprisonment or structural reproduction” of violent contexts (2010:39). But if the experiences of Crystal and Lilah are the norm for hypermarginalized people, what, realistically, are the spaces of possibility? Sangaramoorthy (2018) writes about “improvisation,” or the creative strategies that providers in low-resource areas and their highly vulnerable patients enact to engage with a care landscape from which they are otherwise excluded. There is often an implicit notion that people who use drugs have lives that are too chaotic or too mired in everyday suffering to strategize savvily or organize on the basis of their shared criminalization and stigmatization. They are a population subjected to our most problematic notions of what constitutes a so-called “suffering subject” (Robbins 2013). Much can be learned from the deeply personal narratives of struggle that women like Crystal and Lilah share, because in these narratives the brutal aspects of the care assemblage are revealed. Crystal and Lilah demonstrate the profound paradox that their proximity to death is also a space of relief. The precursor to stabilizing SSI or access to housing is bodily degradation and the advancement of illness to a point of fatality, exposing the tragic reality of deeply embedded processes of social exclusion for people who use drugs.

People who use drugs, in their everyday engagements with a politics of death, provide us with ethnographically rich sites for examining survival-based improvisation under the War-on-Drugs-conditions of stigmatization and criminalization. The task at hand is to critically engage with how these expert improvisations, grounded in the experiences of people who use drugs, can be the foundation for how we recraft care assemblages. If, as Sangaramoorthy (2018) outlines, savvy providers and patients are experts in practicing “band-aid care” in broken systems, can these alternative systems be brought in to mainstream discussions about generating new, less punitive, care landscapes? People who use drugs and other marginalized populations forged innovative interventions such as syringe exchange to address the HIV epidemic; now people who use drugs are at the front lines of addressing our contemporary overdose crisis (Lopez et al. 2018a) to halt death in the spaces where penalization is deeply entrenched. These movements have been made in

the direst of circumstances, while organizers themselves have fought for self-survival. The community-based harm reduction movements of marginalized people who use drugs has long engaged directly with the paradox of compassion and brutality among people who use drugs. These are the sources of expertise for how to create true spaces of respite and care within violent systems.

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