2021

[Introduction to] Paradoxes of Care: Children and Global Medical Aid in Egypt.

Rania Kassab Sweis
University of Richmond, rsweis@richmond.edu

INTRODUCTION

LIKE OTHER PEOPLE WHO GREW UP IN THE UNITED STATES, I WAS exposed to images of suffering children in faraway lands from a very young age.[1] Television advertisements, in particular, first drew me in to this depoliticized suffering, which was, to me, clearly written on tiny, emaciated bodies, torn-up clothes, and the impoverished surroundings in which children were featured—a run-down village in Latin America or a crowded urban slum somewhere in Africa. These children were almost always captured on camera alone. Their singular, vulnerable faces gazed up at me, the viewer, as I was being hailed as a compassionate beneficiary, a savior. Through such media, and long before I began college and earned an undergraduate degree in cultural anthropology, I developed an ethic of global humanitarianism, a charitable sensibility framed around internationalism and responsibility.

At the time, I never thought of asking where these children's parents or communities were, if they even wanted the aid, or what they actually did with the aid once they received it from the organization that was doing the advertising. I never imagined these children as agents with the capacity to decide what they wanted, resist adults, or stake claims in the global aid encounter. More importantly, I never conceived of these children as criminals who could be handcuffed, imprisoned, or even killed by their local police. In fact, local governments and their histories seemed to disappear entirely from these media vignettes. Thus, watching these advertisements from the comfort of my modest yet middle-class home in the

United States, I simply felt bad for the children and wanted to help. As the popular mantra goes: doing something is better than doing nothing.

Today, many of the students I teach at the private liberal arts college where I am employed recite this mantra. A good majority of these students are majors in the global studies program, which has long remained among the most popular programs on campus. But today, in the aftermath of a once-in-a-lifetime global pandemic—the novel coronavirus—many will activate their impulse for "doing something" in the world in the United States. These students grew up as I did, in contexts where the idea of charitable giving to suffering children in the global south was abundant and framed as a responsibility of educated, middle-class citizens in the global north. In the age of COVID-19, even though media cameras (real and metaphorical) still report on suffering across the globe, they increasingly focus more on trouble at home. For instance, Johns Hopkins University's COVID-19 Dashboard tracks cases and confirmed deaths that are both "global" and in the "US." This empathy machine—the media and the conversations that drive students and others to give of themselves, locally and internationally, financially and in embodied ways—belies much of the research present in this book.

My central argument in this book is that global medical aid is a paradox of care for children and medical aid workers in Egypt. According to one definition in the *Merriam-Webster* dictionary, a paradox is "a statement that is seemingly contradictory or opposed to common sense and yet is perhaps true." In the case of humanitarian aid, paradoxes have been well-documented: humanitarian aid, while certainly well-intentioned may be neither humanitarian nor helpful in its implementation. Humanitarian aid can in fact be harmful and self-interested. Therein lies the paradox. When it comes to children and medical aid, this precarity, this paradox, is especially poignant.

I emphasize the concept of paradox throughout this book because the term most accurately captures what I witnessed and experienced while immersed in the complex world of global medical aid for children in Egypt. Paradoxes leave us in a quandary, a conundrum of which there is often no easy solution. Care, especially care for the sick and suffering child, is meant to help, ease, and assist. Care can be work, an aspect of one's chosen career or vocation, but it could also signal love, nurturance, and affection.

For the adult aid givers whose stories comprise this book, their work, their vocation, was certainly an act of care. At the same time, their work maintained or even deepened the social, economic, and political disparities that shaped

children's daily lives. Medical aid comforted the immediate bodily suffering of some extremely vulnerable children, but it also prolonged the conditions that caused sickness and suffering across child populations. As a system embedded in local state structures, global medical aid did little to nothing to change the status quo for vulnerable child recipients. Paradoxically, the work of caregiving frequently had harmful effects on aid givers as well.

Paradoxes are confounding to many of us because they are ambiguous, contradictory, and often unquantifiable. Put differently, they can reflect a situation that is simultaneously beneficial and debilitating, helpful but dangerous. Each aspect of a paradox warrants our deepest consideration and attention. Paradoxes therefore require qualitative approaches to the conundrums they raise, research methods that capture the messiness of lived experience and amplify the voices of human subjects who experience them most intimately.

My findings in this book grow from in-depth, ethnographic research I conducted inside three prominent global aid organizations operating in Egypt between 2007 and 2009. However, the paradoxes illustrated in each chapter are instructive for other circumstances across the globe. Healthcare and humanitarian aid were already of great interest when I began this research, but the novel coronavirus has intensified our world's growing focus on healthcare in times of crisis. Global humanitarianism seems to direct us to care for suffering bodies, in this case, those of distant and distressed children living in poverty.[2] Throughout this book, I challenge readers to engage with the question of what we, caregivers and donors, ourselves gain from such global medical humanitarian transactions. I also urge us to consider the deleterious effects medical care can have on local healthcare workers, particularly those from underserved communities.

If empathy and charitable giving are problematic, as I will suggest, how did we get to a point where conventional views of medical humanitarian aid became so simplified? For one thing, global aid industries repackage large-scale political and economic problems, like global poverty or political violence, into manageable, individual symptoms afflicting autonomous people. This renders systemic human suffering, occurring at the macro-level of populations, solvable through attention paid to singular bodies (the micro-level) and through consumerist practices, such as quick and easy business transactions. The online donation fund for the popular Girl Up campaign is a notable example of this. With one click, I—as a person living in the global north—can donate money to girls in an African village and instantly "Be Part of Change" in a young girl's

life.[3] Many of my students hope to secure gainful employment within the global humanitarian industry to which Girl Up belongs. And the majority will. They make this career choice with good intentions, knowing that the industry is not perfect but that doing something to alleviate human suffering around the world is better than doing nothing while one earns a steady paycheck. These students hold on to this perception even while they spend weeks of sustained, critical study in courses on the ways in which global aid has been shown, by scholars across disciplines, to produce unintended consequences, one of which is to reinforce the global north's material and cultural domination of the global south.[4] However these empirical realities fall to the wayside amidst the power and appeal of contemporary aid industries and what they can promise to do. Indeed, job experiences in these fields are often the springboard to advancement in our world's most powerful professional sectors, such as international law, politics, world trade, and diplomacy.

The personal and professional appeal of global aid work is particularly salient in the case of medical humanitarianism and global health, the industry that is the subject of this book. Overall, medical humanitarianism and global health are on the rise in the United States, as evident in the robust incentives directed at potential medical students every day.[5] These messages forcefully promote international medical aid work as a way in which students can gain "unique experiences," and "bolster a medical school application."[6] Recently, medical students were given early degrees, before passing their final exams, in order for them to enter the "front lines" of the fight against COVID-19. In such a global relationship, who, exactly, is being relieved through medical relief work? Moreover, we know far less about what medical humanitarianism does for the individual people and communities who receive it, but especially children—those perceived as the most passive and dependent, and the most in need of assistance in any society.

Global health, medical humanitarianism, and medical aid (I use these terms interchangeably throughout the book) constitute a form of global assistance that targets the biological life processes of vulnerable groups around the world. It takes, as its primary object of care and intervention, individual human biology rather than economic or political policy. As the anthropologists Peter Redfield and Erica Bornstein suggest, medical humanitarianism emphasizes the physical and psychological suffering of humans above all else.[7] Rather than intervene on economic or political processes, medical aid attempts to alleviate human suffering through healthcare interventions and especially the use of medications.

A prominent example of this kind of work is the "medical mission," in which doctors and other healthcare workers mobilize resources and expertise and travel across borders—either for the short or long term—to voluntarily deliver biomedical care to groups suffering from poverty and/or political crisis. Medical missions are also increasingly on the rise in the United States. Their allure for healthcare workers across the global north is remarkably successful. According to the anthropologist Miriam Ticktin, the contemporary popularity of this work is due, in part, to a "new humanitarianism" that emerged in the 1980s with the work of French-based organizations such as Médecins sans frontières (MSF; Doctors without Borders). This form of humanitarianism fuses healthcare and human rights for the poor, and focuses entirely on the universal bodily integrity of suffering groups. But as Ticktin asserts, this singular focus on biology in global aid shifts action away from collective political reform, where efforts towards crafting lasting solutions to structural problems might go. Instead, medical missions and medical humanitarianism have the long-term potential to maintain the status quo for suffering groups because once the medical workers leave, the underlying problems of structural poverty and dismantled social services persist.[8] And in the case of COVID-19, those who have long suffered the most, namely, underserved and poor communities, especially African Americans, will continue to suffer after the world's cameras shift away from the pandemic.[9]

Despite the contradictions inherent in global medical missions, the overwhelmingly popular view is that they are benevolent and charitable on the part of the people doing the work.[10] This book demonstrates this in some important ways, that is, it reveals how medical aid is considered beneficial by children and aid workers. There is no question that impoverished children in so-called developing countries need life-saving antibiotics and other biomedical resources that are readily available to children elsewhere but not to them. My intention in this book is not to claim that such assistance is wholly harmful. On the contrary, I have witnessed all too frequently while conducting this research how the intervention of a healthcare worker and their use of medication immediately remedied a child's painful infection or bleeding wound. My argument rather is that a singular focus on this (obviously) benevolent side of medical aid work masks the unintended and contradictory effects it produces, consequences that we must confront if we truly care about the long-term health and welfare of vulnerable children. We must remember, for example, that the word "mission" likens global medical aid work to the colonial encounter itself, repeating a legacy whereby colonizing countries

sent doctors along with religious leaders and government officials to help "save and civilize" distant non-Christian populations.[11]

Paradoxes of Care builds upon critical studies of medical humanitarianism and global health to grapple with the messy, contradictory, and real-world effects of global medical interventions with children in one place—contemporary Egypt. It asks the question of how children there receive global medical aid and then it traces what that aid does, or does not do, for them over time. My interest in these questions stem from an urgent need to hear vulnerable children's voices in the Middle East.[12] At present, a glaring paucity of Middle Eastern children's full experiences of global aid persists in social science scholarship, and even fewer accounts exist about children and global health more broadly. Instead, the aid recipients that typically appear in critical studies of global health or medical humanitarianism are adults, with little to no scholarship focusing exclusively on children, child bodies, or child-centered humanitarian policies. This gap in research is even more pronounced in Middle East Studies, which is particularly surprising, since children in the region are labeled the most vulnerable of vulnerable populations and are often the first targets of global intervention. Their bodies are routinely featured in popular media and aid policy in ways that emphasize their victimized and undeveloped status—ways that mark them as different and more vulnerable than suffering local adults. *Paradoxes of Care* provides a timely window into the human relationships, practices, and challenges attached to global medical aid for children from the perspectives of child aid recipients themselves.

The research in this book is based on over two consecutive years of ethnographic fieldwork in Cairo and an upper Egyptian village in three prominent global aid organizations based in France, the United States, and the United Kingdom. In many ways, Egypt was the ideal site for this study, because it is the Middle East and North Africa's largest and most populous country, with a growing population of children living in conditions of extreme poverty. It is one of the world's largest recipients of U.S. foreign aid and remains a vibrant global hub for international aid and development initiatives. This has been the case since the 1990s, when the Egyptian state, like others across the Middle East region, adopted new legal initiatives focused on global health and children's rights, alongside economic packages promulgated by the World Bank and International Monetary Fund.[13]

As an anthropologist intent on embedding herself in all aspects and levels of the global aid industry, I worked in the offices of these organizations as an unpaid intern in exchange for research privileges. I sat in on meetings and assisted

workers as they developed policy reports, statistics, and grants for health-related aid policies. These experiences gave me rich insights into the everyday work lives of the high-ranking administrators and medical experts who produced humanitarian policies for children in the country.

Beyond aid offices, I conducted multi-sited ethnography with medical aid workers as they delivered vital care to children.[14] This movement across sites allowed me to follow workers and conduct interviews and observations in all the places where they assisted children, including a homeless children's shelter, a mobile medical clinic, a child psychiatrist's office, and a village youth center. In all of these locations, I participated in medical aid delivery myself and strove to care for children in the best ways possible. Cleaning children's wounds, teaching children healthcare practices, and completing medical logs for doctors allowed me to better grasp the intimate and embodied experiences of local aid workers. Participant observation also opened me up to children's reactions to my care, illustrating to me, firsthand, how limited that care was in addressing their conditions and the causes of their bodily wounds. The majority of the vulnerable children featured in this book fell into two main groups the aid organizations considered to be the country's "most vulnerable young," street children and out-of-school village girls.

The extended time I spent tracing medical aid encounters between street children, village girls, and medical aid workers across different sites and at different scales allowed me to understand aid outcomes beyond the conventional binaries of good/bad or failure/success. Instead, global medical aid for children appeared paradoxical, first, because it provided immediate relief for some child groups in the absence of other structures of care, mainly formal, state-funded public healthcare. In this respect, medical aid was emancipatory; it afforded vulnerable children at least a partial set of resources that they would otherwise not have. In addition, it granted them new systems of social solidarity to draw on, as well as compassionate engagements from adult healthcare workers during aid encounters.

At the same time, global medical aid had harmful effects for children. Global aid policy framed children as passive, compliant, and purely innocent sufferers. It constructed them through a model of the child based on international children's rights, whereby children are autonomous subjects yet entirely dependent on adults. While on the surface these approaches to the child may seem accurate or necessary to a concerned, middle-class population in the global north, they nonetheless eclipsed children's individual agency and decision-making capacities in places where they must be empowered, such as the streets of Cairo or an

impoverished village in southern Egypt. This elision of agency in policy silences children because it renders their political and economic participation invisible, as well as their status as objects of state violence and control. It ignores the various ways in which children have been empirically studied by scholars of cross-cultural childhood as active agents in their own right. In these works, children are subjects who shape social relations and the world around them; they are meaning-makers rather than passive objects who simply absorb their circumstances devoid of power.[15]

The children I came to know intimately and on a daily basis during my time in Egypt had to assert their agency while managing extreme poverty and structural violence every day. They were caretakers as well as dependent subjects who negotiated social obligations and kinship ties alongside their vulnerable humanitarian recipient status. Poverty persisted in their lives when they were not in the care of global aid organizations. And yet, global aid policy constructed them as passive, pure sufferers and as victims who should naturally accept the resources, care, and governance adult humanitarian aid workers provided. For these children, accepting an ascribed victim status also meant an elision of their power and their own calls for collective social justice—for safety from the police and for economic equity. This was why, as the following pages will demonstrate, children often decided to reject medical aid and adult care, opting instead for independence from aid workers and a sense of control over their own bodies and lives.

Moving beyond global policy to the humanitarian encounter itself, global medical aid could be harmful for children because it often worked to govern their daily practices as it did to heal superficial wounds or prevent infections. Aid workers strove to instill new biomedically "healthy" habits into children according to global policy recommendations. This process was designed by health experts to be in the child's best interest, but many of the children I observed resisted some form of biomedical intervention, because it required a degree of docility from them that they were unwilling or unable to give. Rather than passively receive care, as policy assumed, these children attempted to reshape the humanitarian encounter itself according to their own desires and in ways that increased their power with aid workers. In turn, humanitarian doctors and other aid experts had to reshape their medical practices in order to meet children's demands. The result in humanitarian aid delivery to children was a medical encounter where power between the aid giver and receiver moved both ways, resembling what the anthropologist Jean Hunleth calls a "two-way street."[16]

Given these complex and contradictory realities, in this book I approach global medical aid for the child less as a panacea for childhood bodily suffering and more as a form of humanitarian government that attempts to craft healthy child populations through discipline and regulatory biomedical interventions. As scholars of humanitarianism have shown while drawing on the work of the late French philosopher Michel Foucault, humanitarian government attempts to manage vulnerable populations by focusing on individual biological life processes. This approach recognizes global humanitarian action as a key tactic of "government," whereby power exceeds the interventions of the state to include international nongovernmental bodies like aid organizations. Working from sites spanning sub-Saharan Africa to western Europe, these scholars contend that compassionate engagements and care work focused on the body are absolutely central to the work of humanitarian government. They have also shown how humanitarian government invariably produces hierarchies among human beings (for instance, who constitutes a worthy humanitarian subject and who does not?), since "humanity" itself within humanitarian government is in flux and increasingly conceived of as a manipulable object.[17] My approach to humanitarian government is similar to those of these scholars, but it extends their work by moving beyond the normative adult body as the key site of global medical humanitarian intervention and government practice to explore the universalized and suffering child body as an object of global care and regulation.[18]

In the context of this book, therefore, I conceive of the work of global medical aid best through the metaphor of a Band-Aid being placed, time and time again, on a deep and recurring wound.[19] Band-Aids can be helpful, but they are superficial and designed to manage the most minor of wounds. They offer temporary relief, but do not get to the heart of the problem, in this case, childhood bodily illness and suffering born from social, economic, and political disenfranchisement. In addressing biological pathologies, in attempting to manage children and produce new "healthy" child subjects, global medical aid in Egypt kept the structures that caused children's suffering intact while repositioning children as victims, and as passive objects of the aid organization's care. In other words, global medical aid remedied some individual wounds but it left the forces that produced those wounds untouched—forces that continue to shape countless children's lives in and beyond Egypt.[20]

Global medical aid for the child in Egypt is paradoxical in other ways. Each chapter of this book highlights a paradox from the perspectives of local aid workers

who understood their roles as dually beneficial yet limiting, and as promising yet frustrating. The vast majority of these workers were Egyptian doctors, lawyers, child-rights activists, and other healthcare workers who were part-time employees of global aid organizations and who worked other jobs to supplement their incomes. They forged intimate relationships with children as they attempted to assist them while meeting global policy goals. These aid givers frequently renegotiated and improvised their medical practices in order to manage the unintended consequences of aid—those gaps left open between global aid policy expectations and unanticipated grounded realities.[21]

One notable consequence of global aid with children was the gendered hierarchy medical interventions intentionally or unintentionally established between children on the ground. For example, vulnerable girls were deemed by aid workers to be among the most innocent of children and therefore the most worthy of assistance, while homeless and overly active boys were deemed the most threatening of young people, and thereby the least worthy of care. In this way, there were clear-cut differences in how children were approached by workers and in policy. Workers understood these distinctions through a mixture of local cultural knowledge about gender, class, and generation and the global aid policy they received from the organization they worked for. To echo Didier Fassin, who has written extensively on the moral economy of international aid, not all bodies are equal under humanitarianism. Indeed, as I will show, the bodies of children who received medical aid in Egypt were gendered bodies, both in policy and in how aid was distributed. Workers recognized that these gendered disparities shaped how they provided care to children, and they often grappled with the discretionary power they held during aid encounters.[22]

Even when this work came with professional entitlements like paychecks and valuable experience, medical humanitarian aid work was arduous labor for these workers. They dedicated a great degree of emotional and physical labor to caring for street children and village girls, and it at times went unnoticed in formal policy. Moreover, their work often pinned them against local authorities who resisted foreign aid intervention or exacerbated children's suffering (as was the case with the police). Ramah McKay points out, in a study of global health in Mozambique, that biomedicine is always "enacted through situated practices informed at once by transnational flows of funding, materials, and knowledge, and by located [. . .] practices of care."[23] Similarly, these aid workers consolidated their local knowledge of culture with global biomedical expertise in an effort to

achieve the best aid outcomes possible for children and themselves. In this respect, *Paradoxes of Care* offers new insights into how global medical aid shapes both the givers of aid—from low-level volunteers to paid physicians—and its receivers in creative and unforeseen ways.

EGYPT'S PLACE IN THE WORLD OF GLOBAL AID

Located in a strategic geographical zone at the interstices of Africa, Asia, and the Middle East, Egypt occupies a critical place in the world of global aid. But recently, the entire region has made headlines because of its association with human suffering. In 2018, the United Nations High Commissioner for Refugees (UNHCR) along with the United Nations Children's Fund (UNICEF) deemed the Middle East and North Africa hosts to the world's largest humanitarian crises since World War II, and that due to protracted conflict, political transition, and civil unrest in Syria, Yemen, Iraq, and Gaza, a "staggering" number of vulnerable people—nearly seventy-one million—reside in the region, and the majority of them are children.[24] Indeed, the vast size and scale of recent humanitarian crises in the Middle East and North Africa have made news headlines and colored policy reports for over a decade now, framing the region as an explosive disaster zone, a place of immense human suffering, and a salient site for compassion-driven intervention. But the discourses and images that frame the region as a site of intervention have been with us for far longer than our contemporary humanitarian crises. Like Africa, which anthropologist Liisa Malkki has researched, the Middle East has "embodied need" on a regional scale since its colonization.[25] In its modern history, Egypt was colonized first by the French in the eighteenth and nineteenth centuries, and then by the British up until the early twentieth century. Due to its rich natural resources, including the majestic yet seemingly ungovernable Nile River, and its political location as a strategic U.S. ally, Egypt has remained an object of Western technical and developmental expertise.[26] Indeed today, Egypt is among the world's largest recipients of U.S. foreign aid.

In the aftermath of 9/11, American-based global development institutions have framed Egypt as an explosive zone of crisis, mainly due to Western fears of Islamic extremism and the steady growth of its unemployed young populations, especially poor boys and young men.[27] Egypt is the Middle East and North Africa's largest and most populous country, with roughly half of its population of nearly one hundred million falling below the age of thirty. The global aid policy approaches this young population through a curious mixture of compassion and

fear. Ananya Roy explains this fear as an aftereffect of 9/11, whereby the Middle East is imagined by international aid experts as a "hot spot" of violence in urgent need of remedy if the United States, and the entire global north for that matter, is to enjoy safety and security.[28] Thus Egypt's reputation in the offices of global aid organizations as a "ticking time bomb" paints its young and growing population as vulnerable and as a global political hazard. Such global aid metaphors of the young incite fear in the global north because they are economically and racially informed. These perceptions cast Egypt's masses as other—as young, Muslim, and poor—and potentially angry should their present-day demands go unnoticed.[29]

Global health policy for Egypt similarly establishes itself through these discourses of vulnerability *and* threat, positioning the bodies of vulnerable children as embodiments of the future developing nation. In this aid policy, children are constructed as the drivers of the future national economy. Their improved health, as policy reports assert, will help engender future peace.[30] Thus, global health policy for Egyptian children is framed by policy experts around ideas of national progress, where a temporal dimension to the supposed threat they represent exists. This same policy urges government bodies, donors, and concerned publics in the north to act quickly and intervene, to save these children, before their bodies grow and they become adults. The discourse incites compassion for vulnerable children in Egypt, but it also ignites fears about what is to come, both there and globally, if the health of these young populations is not prioritized. Each chapter of this book offers a critical policy analysis on an aspect of medical aid, and suggests that stereotypes about Middle Eastern or Islamic "cultures" frame key dimensions of aid discourse for Egypt. These cultural stereotypes are attached to Egyptian children and their communities, and are maintained through seemingly apolitical biomedical "facts." Such policies, I show, are designed by aid experts in the global north with powerful public and private donors in mind, including ExxonMobil and Nike. Like biomedicine itself, these policies are not "culture free."[31] They carry with them a set of assumptions about normal "healthy" childhood, as well as about the children they strive to save and their respective communities and "cultures."

Egypt's young population indeed faces a set of generationally specific dilemmas that have worked against them. They are growing up in the aftermath of nearly five decades of aggressive state and capitalist market restructuring, deemed "neoliberalism" by scholars.[32] These processes began in the 1970s with the late President Anwar Sadat's historic *Infitah al Iqtisad* (open door economic policies), which were the result of the Camp David Accords with Israel and the United States.

In subsequent years, a series of structural adjustment programs were promoted by the International Monetary Fund, World Bank, and the Egyptian state. They set into motion policies that eroded many of the economic and social safety nets the Egyptian poor and working classes relied on. These policies increased poverty levels and widened the gap between the middle classes and the poor. Then in 2004, a new set of structural adjustment reforms further struck at the heart of the Egyptian poor, substantially eliminating, among other valuable resources, food subsidies and state-funded public health-care services.

At the same time, vulnerable and poor populations witnessed an increase in state repression, authoritarianism, and police militarization, another aspect of neoliberal state restructuring that has swept through other regions of the world including Latin America and sub-Saharan Africa.[33] It is no wonder then that in 2011 and 2013, the country erupted in a series of mass protests against the government and the effects of these political-economic processes. As the world watched through live-streaming news media, millions of Egyptians took to the streets across villages and cities demanding the demise of the regime and an alleviation of poverty, unemployment, food insecurity, and intensifying police repression.

Another major consequence of neoliberal restructuring over the past five decades in Egypt was the steady proliferation of foreign aid and nongovernmental organizations that claim to operate on behalf of vulnerable poor populations—those that have suffered the most from the retreat of state-funded social services. As anthropologists of globalization assert, these organizations attempt to "do the work of the state" following its dismantling in postcolonial contexts across the Middle East, Africa, Latin America, and Asia.[34] The organizations researched in this book represent this global trend in global humanitarian governance work.[35] They are large-scale, widely recognizable organizations; and indeed, many of my peers and academic colleagues are familiar with them, if not active donors. Although these organizations were distinct in their branding and specific focus, with respect to the forms of care they provided vulnerable children, they were very similar in their corporate, transnational structures and in the policy discourses they produced about children in the Middle East and North Africa. The local workers in the Cairo-based offices of these organizations knew each other well and collaborated across various humanitarian sites to advance the same long-term aid projects across the country. Each of these organizations foregrounded street children and village girls as their primary aid recipients and approached them as bearing the burdens of the intersecting sociopolitical forces I mentioned

earlier. When it came to their medical aid programs, the organizations framed biomedical care work around individual child bodies and their "right to health." They borrowed the language of international child rights and Western categories of the self and family to narrate suffering and craft their standardized policies.[36]

THE STRUCTURE OF THE BOOK

Collectively, the chapters of this book are episodic, and each features a different kind of intervention as it was experienced with a different child group. While each chapter can stand on its own, together the episodes tell a full story about the gaps that exists between global aid policy for vulnerable children and its local implementation. Beginning in a children's shelter, moving on to a mobile medical clinic, then to a child psychiatrist's office, and eventually to a village youth center, each chapter illustrates specific, paradoxical dimensions of medical aid work in practice. The final ethnographic chapter focuses exclusively on the aid workers and child-rights experts who translated international children's rights and global biomedical discourses and remade them into national policy for Egypt. Thus, by moving from the grounded particularities of medical aid with children to an examination of Egyptian expertise inside the offices of large-scale global aid organizations, this book provides a multi-scaled narrative road map for scholars and students of global aid, as well as medical practitioners, aid workers, and concerned publics who hope to make a difference in the world either by providing aid to vulnerable groups, donating resources to humanitarian causes, or becoming more attuned to how global aid sustains our world's enduring inequalities.

Overall, *Paradoxes of Care* confronts the limits of global medical aid for children in Egypt and encourages a reexamination of child-centered medical humanitarian action worldwide. The book does not attempt to offer concrete policy recommendations as to how we can do more or better global aid work for children, although readers can use the book for that purpose if they wish. Instead, the chapters provide empirically grounded answers to some of the most difficult questions plaguing our current moment of global medical relief, such as what, exactly, happens when children are the primary beneficiaries of biomedical aid? I have attempted to capture the relationships that unfold on the ground through that process and from the perspectives of all those involved—children, aid workers, and biomedical aid policy experts. As an anthropologist, I strove to do this with as much ethnographic accuracy as possible, knowing that the "truths"

of anthropological knowledge are always partial and that my own subjectivity as an Arab American woman and Jordanian native shaped the data I was able to collect and interpret.[37]

No ethnographic study is pure and complete. However, it is my hope that the research I provide in the following pages serves as a springboard for deeper and more critical conversations about how children around the world struggle for a good life within the confines of their local situations. I have written the book in a style that, I hope, is accessible to the broadest readership possible yet which nonetheless still illuminates the many complexities and inconsistencies global aid engenders for individual children and aid workers. As each chapter elucidates, vulnerable children work towards their health, safety, and social justice in diverse ways, both with and without global medical assistance. They do so while making decisions for themselves and others, and as subjects who are fully embedded in the promises and perils of local and global politics. As their stories render the model of the child in international children's rights especially problematic and paradoxical, they shed light on the possibility of reimagining "help" for our most vulnerable populations.

This page intentionally left blank