

HALF-HEARTED AUDITORS:
BUREAUCRATIC ORDER AND DISORDER IN HUMANITARIAN AID

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HALF-HEARTED AUDITORS:
BUREAUCRATIC ORDER AND DISORDER IN HUMANITARIAN AID

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Can humanitarian practice be made rational and rule-governed? This dissertation addresses the perplexing co-existence of rationalization reforms and contextual indeterminacy in medical and psychosocial aid. Hoping to exert tighter control over frontline aid practice, aid donors have increasingly favored a form of managerial auditing whereby interventions are broken down into short-term, discrete projects, and reported back in quantitative terms.

Drawing on fieldwork among aid workers operating primarily in Israel and Palestine, I examine how these managerial techniques, and more broadly, expectations of order, interact with daily practice. The rationalization movement in the humanitarian sphere, I argue, has transformed the landscape of aid-giving significantly, clashing often with the priorities of frontline aid workers for whom improvisation and quiet arrangements with locals remain necessary tools for coping adequately with ambiguous needs and fluctuating resources.

Reading humanitarian managerialism as an attempt to reduce uncertainty and derive legitimacy from associations with scientific rationality, I examine its fraught relationship with canonical humanitarian principles of universality and humanity, which numerous aid organizations continue to idealize (even if only intermittently follow). Next, I strive to show managerialism's limits in accounting for aspects of frontline practice. Calls for rationality, I argue, constitute anti-political arguments, framing the successes or failures of aid as hinging

upon the personal ethics and competence of individual aid workers, while neglecting structural factors in aid outcomes, such as short-term funding contracts.

Recognizing that certain aspects of aid cannot be measured, frontline aid workers, project managers, and policy-makers in my account habitually diverge from or undercut monitoring efforts by quietly tolerating various forms of frontline improvisation and discretion. I read such instances less as markers of corruption or subversion than as affirmations of the irreducible contextuality of aid, which is often masked by a language of rationality. The story, however, is not simply of disappointed technocrats seeing their designs fail. Rather, my dissertation accounts for diverse aid actors' own awareness that aid work is difficult to predict and control, and that governance through quantification cannot do away with the delicate frontline negotiations and adjustments that have been present in these (and other) settings all along.

BIOGRAPHICAL SKETCH

Born in Israel, Ilil Naveh-Benjamin completed a B.A. in psychology at York University in Toronto before coming to Cornell University for graduate study. She spent some time studying the politics and practice of experimental psychology before turning to the paradoxes of global humanitarian assistance.

To my beloved family

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Thank you all so much.

LIST OF ACRONYMS

AHE Activists for Health Equality

IASC Inter-Agency Standing Committee

MSF Médecins Sans Frontières

UN United Nations

WHO World Health Organization

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It would, indeed, be of great mutual advantage to the industrious workman, and to the master manufacturer in every trade, if the machines employed in it could register the quantity of work which they perform, in the same manner as a steam-engine does the number of strokes it makes. The introduction of such contrivances gives a greater stimulus to honest industry than can readily be imagined, and removes one of the sources of disagreement between parties.

Charles Babbage, *On the Economy of Machinery and Manufactures* (1835), p. 297

Rules may actually be an impediment to supervision. They may be so voluminous and contradictory that they can only be enforced or invoked selectively.

Michael Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (1980), p. 14

INTRODUCTION

RATIONALIZING COMPASSION

In summer of 2011, I was assigned to write a monthly progress report for a humanitarian non-governmental organization (NGO) working in the Palestinian Territories. The two-page report, which pertained to the organization's medical interventions, was requested by one of the organization's donors, a European human rights foundation. Seeing that I was eager to help with "resource development," a fundraising coordinator asked me to create a spreadsheet with cells for patient attendance, patient characteristics, and conditions addressed throughout the previous month. I was then to add a couple of paragraphs about the benefits of these interventions.

The raw data I was given were a mix of typed and handwritten numbers, but they were curiously incomplete: patients and conditions had been counted for fewer than half of the medical days in question. Based on my conversations with aid workers, I knew that collecting information on each beneficiary in real time was rarely possible. Aid workers contended frequently with more pressing problems such as road closures, volunteer attrition, unpredictable weather, vehicle malfunctions, and miscommunications regarding aid locations and capacities.

After transposing my partial data into a spreadsheet, I brought it to the coordinator for inspection. In her cheerful response, she encouraged me to fill in the missing numbers "as best I could" using previous months' reports as an example. She was careful not to explicitly encourage deception. But her unspoken insinuation lingered as I tried to estimate – or rather, invent – a handful of numbers based on prior months. My estimates skewed conservative: I did not want to inflate the organization's productivity. Nor did I want the numbers to seem too low.

As I wrestled with the moral implications of making such "estimates," a different thought came to my mind: would donors truly care whether 43 or 49 Palestinian women had attended a

reproductive health workshop on this day and in this particular village? Massaging these numbers, the coordinator had implied, would not make much of a difference to either donors or recipients, and I was tempted to agree. Yet I had little basis for judging how often such estimating or “massaging” occurred, nor how frequently it did add up to more significant misrepresentations. If massaging happened regularly in important projects involving large sums of money, then presumably the aid sphere would find itself in a serious crisis of accountability. But what if such actions occurred only sporadically, or pertained primarily to minor interventions?

I did not wish to infer too much about the coordinator’s request. Nevertheless, her matter-of-factness raised compelling questions about the use of numbers in the aid sphere. When do “massaged” numbers mask either negligence or self-interested deception by NGOs vis-à-vis their funders? And when might they instead reflect a more prosaic response to overwhelming reporting requirements that simply cannot be completed on time, at least not without compromising aid delivery? Meanwhile, to what extent did donors expect frontline aid work to be faithfully codified, or indeed, codifiable, in aid settings that contained so many moving parts? And to what degree did aid donors¹ - a term referring here to foreign governments, international foundations and NGOs, and international bodies, such as the European Commission and the World Health Organization, that provide a large share of global humanitarian aid funding –

¹ Given the interests of this dissertation in large managerial structures in the humanitarian sphere, and following the conventions utilized by Hetherington (2011), Yanguas (2012) and Jerven (2013), the term “donor” in this dissertation refers less to private donations (see Bornstein, 2012 for an ethnographic treatment of aid in India that is driven by individual donations) or to religiously affiliated aid organizations (see volume by Barnett & Stein, 2012), than to actors representing larger foundations, NGOs, and governmental bodies, such as foreign governments (for example, SIDA – the Swedish International Development Agency) or international bodies (e.g., World Health Organization, the European Commission). Activists for Health Equality, the main aid organization profiled in this dissertation, publicly lists its donors, and in 2014, they reported over 50 bodies that included Oxfam International, Medico International Germany, La Paiz Maintenant in France, the Ford Israel Fund, the French Embassy in Israel, Evangelischer Entwicklungsdienst in Germany, Diakonia in Sweden, the Global Fund for Women, Christian Aid, and the Municipality of Tel Aviv.

recognize that the numbers they sought from their subordinates, as an objective proof of efficacy, rested in reality upon fragile presumptions of trust?

This dissertation examines the ways in which frontline medical humanitarian aid, in all its indeterminacy, is enacted, audited and governed. Echoing the predicament of the fundraising coordinator, who was required to submit a complete report to a donor even though her frontline aid workers had not had the time to collect all the data, I ask how aid workers understand and act upon the tensions that emerge between policy expectations and frontline practice. How do they reconcile aid mandates and reporting requirements with rapidly changing resources on the ground? And how do they communicate discrepancies among the two to supervisors and donors?

While not focusing on specific reports per se, this dissertation finds aid reports a useful proxy for donors' expectations of order and transparency, on the one hand, and aid workers' efforts to comply with such expectations, on the other. I aim to account for the diverse meanings that are ascribed to aid reports as representations of real-life aid practices, and to position such meanings within a broader analysis of the interplay between rule-governed practice and its presumed opposites – discretion, improvisation, and failure.

The framework of this dissertation was inspired in part by early fieldwork experiences. Witnessing medical and psychosocial aid actors treat Palestinian civilians and asylum seekers from sub-Saharan Africa, I was surprised to see aid workers habituate matter-of-factly to what seemed like a crippling amount of contextual indeterminacy. Tens of thousands of lives hanged in the balance of patchwork medical assistance whose capacities shifted unpredictably on short notice. Patient volumes swelled and donations dried up without warning, putting lives at risk and forcing aid workers to improvise alternatives quickly. If there was anything like a

predetermined plan, policy or quota being followed, it was usually difficult to infer it from circumstances I witnessed or from speaking with aid workers. Yet each time I wondered how humanitarian aid could keep functioning under such fragile conditions, it somehow carried on amidst numerous missteps. Even more surprisingly, no one in the front lines seemed too surprised about its indeterminacy, even in periods when aid seemed to unfold as a series of lurches from one barely avoided disaster to the next.

If I was surprised to witness such matter-of-fact disorder, it was because I knew that these NGOs were required to plan and report their interventions to supervisors and donors in terms of discrete, measurable benchmarks (Barnett & Weiss, 2008; Ebrahim, 2003; Stein, 2008). This late 20th century development reflects a growth of humanitarian managerialism, which equates quantitative measurements of interventions with assurances of their efficacy (Ebrahim, 2003; Prior & Barnes, 2011; Rottenburg, 2009). Watching these aid workers in action, I could only presume that unless much of the disorder I was witnessing was being hidden from the higher ranks, more subtle processes of policy-practice reconciliation had to be operating behind the scenes with the knowledge of multiple aid actors at all ranks.

Managerialism as a philosophy of governance is not unique to aid; it has transformed numerous public and private bureaucracies throughout the global North and South (Brodin, 2008). But in the aid sphere, managerial reforms raise unique questions. For example, how do humanitarian gifts change, both symbolically and concretely, when subsumed under a managerial order? How do efforts to give aid unconditionally to those who are most in need alter when both “needs” and their solutions are increasingly defined in terms of measurable components with short-term timelines?

In this dissertation, I address such questions through an ethnographic study of medical and psychosocial aid workers operating primarily in Israel and Palestine. On a day-to-day basis, aid workers struggle to reconcile competing humanitarian priorities: should they provide immediate assistance to the most people they can, or should they lobby better resourced organizations and government to step in and assume responsibility for the sake of the population's long-term survival? Wherein lies the most urgent crisis? Which conditions should they aim to treat, and in what ways? These questions often lack clear answers, yet decisions must be made quickly even as resources and needs change on a daily or hourly basis. In the chapters that follow, I examine how aid indeterminacy arises in daily practice, and how it challenges efforts to instill order upon the front lines from afar.

The degree to which aid work is context-driven and unpredictable or orderly and rule-governed depends, of course, on who is judging, as well as on the logistical challenges present at each aid setting. Therefore, such questions cannot be answered in any general way. Nevertheless, this dissertation aims to make an empirically-grounded intervention into the subject by situating these questions within particular medical and psychosocial interventions. How closely do such interventions cleave to policy makers' intentions? How do aid actors understand their own successes and failures? Could seemingly disorderly elements, like discretion, improvisation, and even failure, help to sustain aid work, even in an age of increasing rationalism?

The stakes involved in these questions are considerable. Donors' reporting requirements embed particular normative assumptions about what good or efficacious aid consists of. For example, donors who expect primarily numerical reports about aid outcomes, such as how many Palestinian women attended a particular health workshop, may discourage NGOs from engaging

in interventions whose specific impact is harder to measure, like conversations that aim to increase local women's awareness of local health services. In this manner, audit practices change not only how interventions are assessed, but also what kinds of interventions are enacted in the first place. As Judith Burton and Diane van den Broek's (2009) put it, audit reforms in service bureaucracies are not just about doing the same things differently, but about doing different things altogether.

To examine the relationship between aid mandates and practices, I draw on three main literatures: work in science and technology studies (STS) on the relationship between political order and knowledge, critical scholarship on aid and development, and studies of organizational and audit cultures. Below, I examine these literatures and explain how their common concerns are taken up in this dissertation.

STS AND HUMANITARIAN MANAGERIALISM

STS scholars share a long-standing interest in the relationship between knowledge and social order. As Langdon Winner (1986) has pointed out, scientific and technological systems help to order and re-order social and political life in profound ways. The Haussmann-influenced construction of wide Parisian boulevards in the mid-19th century, for example, was intended not only to curb violent uprisings and alleviate over-crowding, but also to curb mass protest and other forms of popular assembly. An array of physical forms or technologies, in other words, worked to constrain the forms that political dissent could take.

To avoid a deterministic reading of such examples – which might, for example, focus on the capacity of technologies to alter social life without accounting for their contested usages and interpretations or their own circumstances of emergence – STS scholars have increasingly asked how knowledge and political order are *co*-produced. Following Sheila Jasanoff's (2004a)

interpretation of co-production, “knowledge-making is incorporated into practices of state-making [...and] practices of governance influence the making and use of knowledge” (p. 3). The idea of mutual influence is vital: it enables co-productionist accounts of scientific knowledge to avoid both social and natural determinism. Such accounts show, for instance, that scientific theories and practices are not a mere reflection of “nature:” to understand science, one needs to place it in political and historical context. On the other hand, science is not merely a social construction. Co-production is thus helpful in allowing the technical and historical-political dimensions of knowledge to play equal roles in an analysis.

Examples of co-production are wide-ranging, and exceed the realm of science. James Scott (1998), for example, whom Jasanoff (2004b) cites extensively, persuasively argues that the modern nation state sees both its land and its people in terms of simplified, idealized categories that have little to do with the complexity of social life. The state then proceeds to re-order that life accordingly, whether by violent force or by more subtle, but no less powerful, bureaucratic means. Ways of *seeing* the land thereby encourage particular means of *governing* it, and the opposite is also true. The two processes are simultaneous and mutually reinforcing, capturing the essence of co-production.

As I will illustrate throughout the dissertation, co-production is an important concept in understanding how international aid is governed and monitored. For example, requiring aid workers to provide quantitative reports of discrete aid outcomes relies upon and reinforces a particular view of aid practices as being indeed amenable to such classification. This view, in turn, may re-orient aid practices in such a way that those interventions that are easier to measure are gradually prioritized at the expense of those that are not. As Porter has aptly noted,

“[q]uantification is not merely a strategy for describing the social and natural worlds, but a means of reconfiguring them” (1994, p. 389).

Classification is a central link between order and knowledge. As Geoffrey Bowker and Susan Leigh Star (1999) maintain, processes of classification not only sort information into categories that can then be governed, but also constitute a form of intentional forgetting. In other words, they provide a very partial access to the past, and obscure much of it. Yet in contexts where total information is not even desired, this is not only a useful move, but a necessary one. For example, statistics, Bowker and Star observe, can be seen as a “filtering mechanism that allows a central office not to have to remember everything” (p. 255). In other words, statistical methods can help “tame” unmanageable numbers, but in doing so, they make these numbers’ referents visible in certain ways and not in others. As Bowker and Star (1999) note, systems of classification are typically the product of considerable negotiation and dispute. Parties to these disputes worry about their outcomes precisely because they know that vast swathes of information stand to be obscured or accentuated depending on the method of classification that is chosen. And when such classifications carry institutional weight, at stake is nothing less than how social life is governed and ordered.

Technologies of classification, then, obscure as much as they reveal. As Scott (1998) illustrates, for example, cadastral mapping has been an essential tool of modern statecraft. Yet it cannot, nor is it meant to, capture the complexity of social life. Rather, it focuses on land and property information that can assist governments with tax collection, and omits the rest. Such omissions, however, periodically result in important things remaining unseen: “formal schemes of order,” Scott notes, “are untenable without some element of the practical knowledge that they tend to dismiss” (p. 7).

Scott (1998) provides numerous examples of such failure. For proponents of scientific forestry in 18th century Prussia, for example, forests comprised solely of one species of tree were easier to control, count and exploit for valuable lumber than were naturally growing forests. But the former also ultimately proved more vulnerable to decay and disease. Their soils quickly became nutrient-depleted; their underbrush lacked the diversity of flora and fauna that would protect against pests. These forests subsequently died or produced very little. Meanwhile, the human element could also not be controlled: “people living nearby,” Scott notes, “typically continued to graze animals, poach firewood and kindling, make charcoal, and use the forest in other ways that prevented the foresters’ management plan from being fully realized” (p. 19). The management plan’s neglect of the complex biological and social life of forests provides an apt metaphor for governance in modern nation states.

Although cadastral maps, statistical methods, and other technologies of simplification necessarily omit information, they are a necessary part of governance from a distance. Quantification, in particular, facilitates governance by casting knowledge objects in terms of common measures. As Jasanoff (2004a) notes, a key interest among STS scholars has been how scientific objects are made *portable* and *intelligible* across time and space. For Theodore Porter (1995), for example, quantification makes knowledge objects portable: it is a “technology at a distance” that generates trust among actors by establishing a common metric of comparison that is agreed upon by actors of diverse backgrounds, and is aligned to a “spirit of rigor” (p. ix, 74). Such technologies are also key components of state building, as the 20th century use of statistics in the rising social sciences to classify individuals in terms of educational ability, criminality, military fitness, illness, and rates of insanity can attest (Danziger, 1997; Hacking, 1990; Rose, 1988, 1996).

Yet as numerous scholars have noted, quantification practices do not simply create trust: they also rely on it (Downer, 2012; Harper, 2000; Porter, 1995; Power, 1997; Strathern, 2000). For example, John Downer (2012), writing about aviation safety, observes that Federal Aviation Administration staff in the United States, who are in charge of assessing the safety of aircraft, typically lack the high-level technical expertise to do so themselves. To cope with this “epistemic barrier,” he argues, they “regulate at a distance” by deputizing engineers to conduct evaluations and trusting their assessments (p. 83). The regulation of safety, in other words, despite a guise of objective assessment, still rests fundamentally upon human trust. As STS scholars have shown, then, numbers themselves do not produce self-evident proof or immediate consensus; their uses are often ambiguous and socially contested (Harper, 2000; Jasanoff, 2004b; Porter, 1995; Timmermans & Berg, 1997). At the same time, political profit often stands to be made from assuming or arguing that numbers do possess such an inherent objectivity.

To sum up, then, STS scholars have emphasized the importance of classification and quantification in allowing governments to construct, manage, and compare large amounts of information about their populaces using a common quantitative idiom. The political utility of numbers is tacitly understood by many, but is not often explicitly couched in political terms; rather, in numerous institutional settings, numbers are valorized as presumed bearers of objectivity, rigor and transparency.

A similar view of numbers has punctuated the recent history of humanitarian assistance. The final years of the Cold War marked an important shift in the global aid architecture: global powers began to gradually recede from direct aid provision, switching instead to funding various intermediaries, particularly local and international NGOs, to carry out their humanitarian impulses (Barnett & Weiss, 2008; Stein, 2008). Increasingly removed from the front lines, donor

countries sought to compensate by engaging in more frequent monitoring, measurement and reporting of aid's consequences. Other donors (private foundations and international political bodies) followed suit. All have been aware of the mutual dependency among aid agencies and funders: the former may depend on the latter's funds, but the latter are no less dependent upon the political capital that accrues from being, or being perceived powerful enough to be, an international aid donor (Ebrahim, 2003).

Two additional developments are sometimes credited with contributing to the growing culture of aid monitoring and evaluation (Fernando, 2012). The first is the 1994 Rwanda genocide of nearly a million Tutsi. The genocide's aftermath marked a wrenching period of self-reckoning for dozens of aid organizations that had made no distinction among combatants and victims. Giving aid unconditionally to both camps, they unintentionally rendered some refugees and survivors vulnerable to slaughter. As Michael Barnett and Thomas Weiss observe, "the spectacle of aid agencies feeding the perpetrators of the Rwandan genocide alongside victims presented harsh lessons about intentions" (2008, p. 7). Rwanda was by no means the only tragedy to raise concerns about aid's consequences, but the horrifying atrocities committed there infused old debates with a new measure of urgency (Leebaw, 2007). Donors vowed to spend less time extolling good intentions and more time monitoring aid closely in order to ensure that disastrous harms were avoided in the future.

A second development involves late 20th century governmental concerns about the efficiency of U.S. and UK public sector bureaucracies. Such concerns, which peaked during the Reagan and Thatcher eras, are widely credited with contributing to a series of gradual management reforms collectively known as new public management, or managerialism. These two terms refer loosely to corporate-derived management philosophies that prioritize

performance-based incentives and regular measurements of performance (Hjorne et al., 2010; Kerr, 2005). Efficiency is the “primary yardstick” for success, and it is often defined in terms of quantitative targets (Tsui & Cheung, 2004, p. 439).

Managerial philosophies are not a unitary or monolithic form of governance. Indeed, they are often associated with seemingly contradictory expectations. On the one hand, workers are encouraged to monitor themselves and make themselves more diligent and vigilant about the quality of their own work (Ebrahim, 2003; Prior & Barnes, 2011; Rose, 1996). Yet in many accounts of new public management, workers are at the same time subjected to constant monitoring from above, often taking the form of “performance management (e.g. auditing, contracts, targets and timetables) and planning and control cycles (e.g. feedback systems, assessment and review systems, information and communications technologies)” (Hjorne et al., 2010, p. 306). While according high value to both self-governance and tight monitoring from above may seem contradictory, following Foucault’s discussion of technologies of the self (1988), we may consider them two sides of the same token, both angling toward the same overall effect.

New public management principles transformed public sectors in earnest throughout the 1980s and 1990s, starting primarily with the United States and the United Kingdom (Shore & Wright, 2000). Aid and development organizations, too, jumped on board. While similar reforms had already been underway in the aid sphere since the 1970s (Kerr, 2005), more recent white papers, conventions and declarations have entrenched earlier commitments (Mosse, 2004). Foremost among these has been the 2005 Paris Declaration on Aid Effectiveness, which saw donors and NGOs uniting over mutual promises of superior efficiency and accountability through closer supervision of how aid workers use the resources they are given.

The “new” accountability of managerialism emphasizes quantification as a proof of efficacy, in contrast with the “old accountability” of service bureaucracies that had emphasized professional ethics and welfare legislation (Hjorne et al., 2010). “New” accountabilities in the aid sphere, writes aid scholar Rosalind Eyben (2011), “requires you to state a purpose – for example, increased incomes for landless families – and then work out what a project can do to achieve that purpose” (p. 21). In contrast, she argues, aid projects in Britain in the late 1980s “did just the opposite: an available technology was identified accompanied by a half-hearted effort to justify its use for improving the world” (p. 21).

Managerial reforms have not been purely about better control or even superior accountability. Rather, a cultural revolution has also been underway. As James Scott notes, the introduction of the metric system in France “was at once a means of administrative centralization, commercial reform, and cultural progress” (1998, p. 31). Rationalizing and standardizing measures, it was hoped, would in turn create a “rational citizenry” (p. 32). Managerial reforms in the aid world, I argue, have embodied similar hopes. As Emma Mawdsley notes, aid donors “project particular identities through their development cooperation discourses and policies” (2012, p. 145). Such identities express “prestige, solidarity, and power” to peer donors and to recipients, both domestic and international (p. 145).

An increasingly central component in these performances has been an earnest belief in rationality, or “the capacity for humans to control the world through thought, logic, and calculation” (Peet & Hartweek, 2009, p. 107). This belief, in turn, invokes “[e]nlightenment notions of the intervention of the modern, scientific, and democratic mind into the improvement of human existence” (p. 3). Recalling Jasanoff’s treatment of co-production (2004b), forms of governance often carry with them particular theories of knowledge. Along these lines,

managerial reforms presume a view of aid as (ideally) comprising actions that can be divided into discrete, measurable, and knowable components – a view that both legitimizes and aids in the governance of its knowledge objects. Indeed, aid organizations increasingly work hard to present themselves as bearing such an epistemology (Ebrahim, 2003).

Yet in the trenches of humanitarian assistance, things can often look quite different. Reports to donors are increasingly plentiful, but as numerous studies have shown, they do not always faithfully reflect what happens in the front lines (Ebrahim, 2003; Ferguson, 1990; Mosse, 2004, 2005; Yarrow, 2011). In reality, aid workers often report having little time to collect the relevant data, and much of what happens in daily practice cannot be measured. Moreover, responses from donors are not always meaningful; as Alnoor Ebrahim (2003) points out, there is overwhelming evidence that donor staff typically lack the time to read and respond thoroughly to reports.

On a discursive level, moreover, there is ample talk of learning from mistakes and of engaging in meaningful discussions in order to improve the quality of aid for the benefit of recipients. Yet on a daily basis in the trenches, critics argue, pro-forma practices dominate on both donor and NGO sides, and critical thinking about past failures is often stymied by the tendency to define outstanding problems in terms drawn from within the managerial lexicon, instead of outside it (Ebrahim, 2003; Kerr, 2005; Stein, 2008).

Managerialism enthusiasts suggest that tighter monitoring and reporting will help create a knowledge base about what forms of aid are most efficacious, to the ultimate benefit of aid recipients (Baingana, 2004; DFID, 2011). Yet reports are rarely shared with peer organizations for the sake of knowledge building, whether due to translation issues or fears of competition (Cooley & Ron, 2002). A related critique, noting that managerialism inundates workers with

paperwork, questions whether managerialism can live up to its own promises of efficiency (Shore & Wright, 2000). Writing about social workers in Australia, for example, Burton and van den Broek (2009) noted that some of them have to work with “six or seven very different data collection mechanisms” on a daily basis (p. 1337).

Similar stories are ubiquitous in the aid sphere. As Ebrahim (2003) notes, some “NGOS are not opposed to collecting data based on the logical framework, but are concerned, in retrospect, about the volume of data” (p. 93). Other NGOs, meanwhile, engage in active resistance to managerial requirements, partly through deliberately uninformative reporting that does not tell donors much about actual daily practice (Ebrahim, 2003; Mosse, 2004; Rottenburg, 2009). This is one way frontline aid workers can wrestle some power back from donors, argues Ebrahim (2003), yet it has the ironic effect of entrenching the hegemony of quantitative measures of efficacy by complying with them in a perfunctory way instead of openly questioning them.

The policy-practice tensions I have described so far could apply to any service bureaucracy. But as I noted earlier, the humanitarian context adds important questions of its own. For example, how might measurement norms affect aid interventions whose impact is hard to measure? What challenges might managerialism thereby pose to long-standing humanitarian traditions? Aid organizations often subscribe broadly to a set of guiding principles widely traced to the founding of the International Committee of the Red Cross in the 1860s (Barnett & Weiss, 2008, 2011). These include humanity, which is the notion that all people deserve equal life-saving assistance, without regard to their country of origin; impartiality, which emphasizes equal treatment of all aid recipients regardless of their ethnicity, religion, race, or gender; and neutrality, or not taking part in any violent conflict or aligning with any state’s interests.

Such principles articulate ideal types, which aid actors increasingly recognize as difficult to actualize. For example, NGOs are increasingly funded by states and dependent upon their financial and military resources to keep aid routes clear and safe (Hoffman & Weiss, 2006; Terry, 2002). Other aid organizations have found themselves providing indefinite welfare services and state-building functions to compensate for failing governments, muddying up notions of “pure” relief even further.

While aid’s entanglement with states is increasingly recognized, the fantasy that aid might somehow remain apolitical despite all this retains high value in the humanitarian sphere. Perceived purity of intention and action are romanticized, and explicit involvement in certain forms of politics is often condemned as a “moral pollutant” (Barnett & Weiss, 2008, p. 4). These debates about the purpose of aid are not simply lofty identity struggles; they carry important practical consequences. For example, for aid workers in conflict zones, the semblance of neutrality is crucial in protecting them from militias and reassuring recipients of their genuineness of their intentions.

The consequentialist language of managerialism poses a challenge to principles of humanity, impartiality, and neutrality. How can aid be unconditionally granted, for example, when it is subject to quantitative calculations of efficacy? How might notions of goodness and caring be codified in efficacy reports? In the following section, I flesh out these questions by situating them within a critical literature on aid and development. If STS can help us to understand the symbolic and political work that quantification practices can perform, from bestowing legitimacy upon their users to changing the boundaries of knowledge objects, then critical development studies would frame such work in terms of its impact on aid recipients. Managerialism’s quantitative emphasis, several aid scholars have argued, has often prioritized

upward accountability – the needs of donors – at the expense of the desires of aid recipients (Ebrahim, 2003; Kerr, 2005; Kos, 2008; White, 2010). For example, managerialism might jeopardize interventions that recipients may perceive as genuinely helpful, but which are not codifiable in ways that donors might desire or expect.

As STS scholars would remind us, rationalization efforts in the aid sphere are capable not only changing how aid is governed, but also of constructing new understandings of efficacy, while redefining needs and aid recipients to fit such understandings. This redefining and remaking, however, does not happen on blank slates. Rather, many recipient populations have already been thoroughly scrutinized and remade many times before – whether during prior aid gluts or during periods of colonial rule. They thus often struggle not only with the current ills of disaster, poverty, or conflict, but also with lingering patterns of inequality and deprivation that were put into motion by corrupt governments and colonial regimes.

While aid vigorously strives to distinguish itself from the latter two, it sometimes unintentionally mimics them, whether by dabbling in Orientalizing discourses or by pushing on with harmful interventions without carefully considering locals' priorities (Allié, 2012; Escobar, 1995; Ferguson, 1990; Maren, 1997; Said, 1977). Any study of aid governance should be mindful of the tortuous ethical entanglements of aid with postcolonial settings. The following section, therefore, provides a very brief introduction to such entanglements and explains how they become relevant in the study of aid rationalization.

CRITIQUES OF AID AND DEVELOPMENT

Does aid – whether in the form of short-term relief or long-term development – do more good than harm to its recipients? Academic responses to this broad question have often fallen into two competing camps, which Saida Hodzic has termed the “camp of skeptics” and the

“camp of believers” (2006, p. 6; see also Ferguson, 1994; Fisher, 1997; Lewis & Mosse, 2006; Mosse, 2004). The so-called believers’ camp, which has also been called a “policy science” (Ferguson, 1994, p. 10) or an “instrumental” critique (Mosse, 2005, p. 2), generally takes for granted the positive value of aid and development. As Ferguson notes, the language of this camp tends to be “technical and managerial,” focusing on logistical challenges and theorizing ways that aid might combat poverty and suffering more efficiently (1994, p. 10). Proponents of this camp tend to subscribe to Walt Rostow’s (1960) theory of economic growth, according to which developing nations are in need of economic and technological assistance in order to traverse several universal stages of economic growth until they reach that of developed nations.

In contrast, the second framework, affiliated with Marxism, postcolonial scholarship and dependency theory, questions the overall benefit of international aid and development as they have existed since the end of the Second World War. Skeptics read the technical language of the believers’ camp as a thinly veiled re-emergence of colonial-era “civilizing missions,” according to which remote and beleaguered peoples need to be rescued and “civilized” by their technological superior benefactors. A related critique reads the global development apparatus as a means of expanding capitalism throughout the global South in the guise of spreading technology and expertise (Escobar, 1995; Peet & Hartwick, 2009).

Members of this camp reject Rostow’s stages as falsely assuming the universality of European development. These stages, critics allege, lump all “traditional” societies together as equally “undeveloped,” while neglecting their unique strengths (Frank, 1969). The assumption that there are universal stages of growth, moreover, ignores the fact that developing societies have already been irrevocably changed by outsiders during colonial and postcolonial periods alike (Ebrahim, 2003). For example, late 20th century aid to developing nations often required or

encouraged the privatization of certain state services, prompting NGOs to fill the gap (Ferguson, 1990).

Critics have often alleged, furthermore, that aid organizations working in developing countries have unwittingly undermined their class struggles by offering easy-to-adopt but superficial solutions to poverty and violence in order to temporarily quell discontent (Peet & Hartwick, 2009; Hodzic, 2006; Leve & Karim, 2001). Admittedly, a growing number of aid organizations have attempted to address not only the symptoms, but also the root causes of suffering, in what Michael Barnett (2010) has called *alchemical humanitarianism*. But such ambitions often entail fraught entanglements with local governments, and their results have been mixed (Barnett & Weiss, 2008).

Some skeptics consider humanitarian missions a form of “ethical consumption” (Hindman, 2013; Illich, 1968; Mostafanezhad, 2012; Muller, 2013). Aid missions, they note, have not simply aimed to help the downtrodden and forgotten populations of this world, but also to assist self-styled cosmopolitan Westerners in building their policy careers, bolstering their credibility as medical or technical experts, or simply experiencing first-hand the euphoric rush of giving and life-saving. Ivan Illich’s famous 1968 manifesto, “To Hell with Good Intentions,” speaks disparagingly of privileged “dogooders” who desire to experience giving in exotic or remote locations. However satisfied they may feel, he writes, most will likely remain blind to their recipients’ root causes of suffering, and their preferred manner of assistance tends to be self-serving and superficial.

The believers’ camp and skeptics’ camp represent simplifications of more diverse arrays of positions (Peet & Hartwick, 2009). Yet even when viewed as heuristic simplifications, David Mosse argues, “neither of these views does justice to the complexity of [development] policy

making and its relationship to project practice, or to the creativity and skill involved in negotiating development” (2005, p. 2). Several of Mosse’s contemporaries appear to agree, siding more with the skeptics’ camp but see it as giving too much power to the aid industry, whether by painting all aid organizations as “instruments of an emergent neocolonialism” (Leve & Karim, 2001, p. 55) or by falsely attributing to them a “perfect hegemony” over developing societies (Mosse, 2005, p. 3).

There is an important politics of postcoloniality being negotiated in the space between the skeptics’ and believers’ camps. Namely, those who take for granted the basic goodness of what they call “development” can become blind to the occasional superficiality of aid projects’ solutions to global poverty and suffering. But critics, in turn, can reduce all recipients to victims, overlooking their capacity to challenge or renegotiate aid that might oppose their interests. In their review of critiques of development, for example, Africanist historians Frederick Cooper and Randall Packard (1997, p. 18) argue that

critics of development interventions are as likely as proponents to reify the categories of traditional and modern, of “community” and “West,” giving the category of community a positive value instead of negative. Historically, however, the two sides are more deeply imbricated in each other than such a dichotomous suggestion implies.

In Cooper and Packard’s view, critics who see present-day recipients of aid as broadly representing pure, untouched landscapes or as helpless to resist the plans of developed nations for them, are misreading these recipients.

To explain the significance of Cooper and Packard’s argument, I would like to draw upon James Ferguson’s (2006) work on colonial mimicry. In 1998, Ferguson recounts, the bodies of two Guinean teenage boys were discovered in the landing gear of a plane at the Brussels airport.

They had presumably made a desperate, and ultimately fatal, decision to try and smuggle themselves to Europe, without realizing that the landing gear was not pressurized.

One of the boys had been carrying with him a hand-written letter addressed to the “members and officials of Europe,” beseeching them to “rescue” the “people of Africa,” who were beset by “war, disease and malnutrition.” In Guinea, the boys had written, “we have plenty of schools, but a great lack of education and teaching.” They commended Europeans’ “wealth and power to build and organize your own continent so well that it has become the most beautiful and admirable of them all” (Ferguson, 2006, p. 155-6).

“We Africans,” the boys continued, “are asking you to set up a great, effective organization for Africa so that it might make progress. And if you find that we have sacrificed our lives,” they concluded with an ominous premonition, “it is because we have suffered too much in Africa” (Ferguson, 2006, p. 155). Anyone superficially familiar with Africa’s colonial history might cringe upon reading this letter. But for Ferguson (2006), of greater interest is the reader’s sense of embarrassment that two Guinean boys might not only earnestly reproduce a version of the “civilizing mission” discourse that sees all of Africa as benighted and diseased, but also literally sacrifice their lives in an effort to escape this supposed reality.

For Ferguson (2006), the letter belongs to an important genre of mimicry of the so-called developed world by its present or former colonial subjects. Such mimicry and supplication, he argues, has tended to trouble postcolonial scholars, eliciting in some of them a nativist stance (Chakrabarty, 2000) that declines to see mimicry as genuine envy, but rather reinterprets it as an anti-colonial stance in flimsy disguise. In the 1940s, Ferguson writes, anthropologists working in Northern Rhodesia, a British protectorate corresponding roughly to present-day Zambia and Zimbabwe, discovered locals’ apparent fascination with European sartorial styles and

mannerisms (Ferguson, 2006). Locals held European-style ballroom dances in imported French evening wear. Two or three decades later, anthropologists reading these ethnographic accounts were aghast. Invoking Franz Fanon's (1967) interpretation of such mimicry as a pathology of colonization, these scholars rushed to reinterpret these 1940s ballroom dances as forms of mockery or parody of colonial rule. For these scholars, Ferguson (2006) argues, this interpretation was the only conscionable one: "How were they to deal with an object of alterity who refuses to be other, who deliberately aims to spoil his or her own 'authenticity,' and who threatens to confirm "that 'African' ways were inferior to 'European' ones?" (157-159).

Yet what some of these scholars seemingly neglect to acknowledge, Ferguson (2006) suggests, is that acts of mimicry do not necessarily covet another *culture*; they instead crave material wealth, the possession of which holds the promise of a place of respect in a global civil society. This sort of envy offers a rebuttal to those scholars who would seek to salvage their subjects' integrity by declaring them "modern" in a different way, thereby supposedly liberating them from the need to mimic their oppressors. These scholars may believe they are doing their subjects a favor by working against centuries of accounts that presented their subjects as savages in need of taming and civilizing (Said, 1977). Yet as Ferguson (2006) points out, "where the anthropologist extends the label 'modern' to the impoverished African as a gesture of respect and an acknowledgment of coeval temporality, African urbanites who believes their lives will not be 'modern' until they have running water and a good hospital may find the gesture an empty one" (p. 168).²

² Ferguson, Cooper and Packard are far from alone in making this critique. Nativism, or the "desire to return to indigenous practices and cultural forms as they existed in pre-colonial society" is among of the most vigorously debated positions in postcolonial studies (Aschroft, Griffiths, & Tiffin, 1998, p. 159).

I raise Ferguson's (2006) story of the two boys because it offers a poignant illustration, I argue, of how well-meaning hypocrisy and ignorance can emerge within the skeptic's camp. As I mentioned earlier, Cooper and Packard (1997) suggest that aid skeptics are as likely as enthusiasts to reify the categories of traditional and modern. I would make this claim more explicit: while technocrats of development may be wrong to believe they are simply sending knowledge and technology overseas, aid critics are themselves occasionally too quick to presume that aid is by and large detrimental to its recipients and cannot be said to represent their wishes.

With some recent exceptions (e.g. Escobar, 1995), scholars writing today tend to adopt moderate positions somewhere between the skeptic and believer camps (Hodzic, 2006).³ As Mosse (2004) has put it, "[r]ecent ethnography of development has begun to blur the bold contours drawn by both rational planning and resistance/domination frameworks" (p. 644). But even moderates find themselves in a precarious position. Anyone attempting a historical or critical account of aid must grapple with the inequalities that invariably emerge between aid givers and their recipients, as well as with locals' collective memories of prior epochs of exploitation. The horrors of war, disaster, and poverty may be undeniable, but aid is not an objective panacea, and it difficult to strike an analytical tone that neither demonizes aid nor valorizes it while crudely affirming the presumed gratitude or simplicity of its recipients.

In their zealousness to protect aid recipients, some critics of aid have failed to take into account the necessity of *some* form of order, some mechanism of formal governance, for any aid

³ Uncertainties over how much power and intentionality to ascribe to development projects in their remaking of landscapes and individuals echoes similar debates over colonial missions. In his study of 19th and 20th century colonial psychiatrists in the Maghreb, Richard Keller (2007) acknowledges that colonial psychiatry provided a vocabulary for discussing normality and pathology, which "informed educational and professional discrimination against Muslims, shaped discourse about immigration into France, and provided the essential background for the French army's psychological warfare programs during the Algerian struggle for independence" (p. 7). At the same time, he writes pointedly, it would be a mistake to characterize these effects as a coherent or organized intention of psychiatrists themselves. Megan Vaughan (1991) similar cautions not to reduce colonial medicine to a tool of racist oppression.

project to be carried out – including projects that strive to be participatory or recipient-driven. Even while noting cadastral mapping’s myopia, for example, Scott (1998) concedes that without it, modern states could hardly tax their populations. Similarly, Bowker and Star (1999) note that in governance contexts, statistics are a necessary simplification method. With respect to aid and development, Cooper and Packard (1997, p. 26) take a similar line, reminding critics of aid that

Large-scale organizations need to simplify; funding cycles demand replicable project designs [...] Academic social scientists should not be dismissive of such difficulties. The historian’s or anthropologist’s concern with context and complexity is neither more nor less separable from a self-serving professionalism than the development practitioner’s concern with the replicability of project design, the desire for stable decision-making frameworks, and the need for a quick and readily graspable analysis of the specificity of each case in which action is being taken.

As Cooper and Packard point out in crisp and blunt terms, no aid can be carried out without a plan. This may seem obvious, but it is often forgotten amidst heated debates about the alleged harms and benefits of aid (Escobar, 1995; Ferguson, 2006). Yet if some kind of plan is obligatory, then to what degree are plans and policies, particularly in an age of rationalization, actually followed in humanitarian trenches, where both resources and needs are prone to constant change? When might frontline aid workers periodically diverge from mandates in order to meet situational demands? And what effects could such divergences have on aid recipients? The next section segues into an important literature on organizational auditing in an effort to explain how such divergences from policy have been conceptualized in bureaucratic settings.

STREET LEVEL BUREAUCRATS: AUDIT CULTURES, DISCRETION AND DECEPTION

The ways in which low-level bureaucrats are monitored and governed by their superiors has attracted attention in diverse fields. In the 1960s and 1970s, organizational and policy scholars began to ask why certain governmental agencies failed to implement policy agendas. In their analyses, policy was a predetermined statement of intent, and bureaucracy was the

ostensibly neutral means of its actualization. Thus, failures to implement policy agendas were interpreted as crises of democracy (Barrett, 2004; Brodtkin, 2008). In an effort to intervene, scholars turned their attention to the presumed subversion of top-down policy by non-compliant public functionaries.

The “compliance model,” as it was called, gradually fell into disfavor. Critics increasingly questioned its hierarchical view of policy as a discrete entity that was either implemented or not (Barrett, 2004; Brodtkin, 2008). For critics of these early “implementation studies,” policy itself was no longer seen as a discrete, static entity, but rather as what Rosalind Eyben has described as a “relational, contested, and never-finished process” (2011, p. 20), reflecting multiple and sometimes competing policy interests (Barrett, 2004; Brodtkin, 2008). This bottom-up view has also held that analysis should begin from the front lines, rather than by tracing policy from the headquarters down.

In this approach, functionaries’ capacity for discretion gradually became a main focus of inquiry (Ellis, 2011). Yet rather than being seen as a sign of aberration, subversion, or failure of implementation, discretion has itself been recognized as a necessary part of daily practice (Eyben, 2011). Policy, accordingly, became both a “statement of intent” and a process that was “mediated, negotiated, and modified” through interaction among policy makers, service workers and their recipients (Barrett, 2004, p. 253). Such interactions, scholars recognized, reshaped policy by creating numerous opportunities for reconciling competing values and contesting each parties’ assumptions about who owed what to whom.

A central text within this bottom-up framework has been Richard Lipsky’s (1980) seminal book, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. Lipsky studied how social workers, police officers, and other public service functionaries worked

directly with members of the public. When faced with chronically low resources and overwhelming demands, he argues, street-level bureaucrats often have no choice but to subvert some rules in order to function in their respective roles. As Lipsky observes, “rules may actually be an impediment to supervision. They may be so voluminous and contradictory that they can only be enforced or invoked selectively” (1980, p. 14).

As Lipsky notes, supervisors and managers working slightly above street level are obligated to expect obedience and order from their subordinates. But in reality, the discretion of street-level bureaucrats, he argues, is something that managers increasingly recognize as being vital to the success of their profession. Lipsky further claims that “the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out” (p. xii).

Lipsky’s work inspired dozens of studies on street-level bureaucracy (e.g., Ellis, 2011; Evans & Harris, 2004; Watkins-Hayes, 2009).⁴ For Lipsky, however, not all discretion was a good thing: he expressed concern that discretionary power would tempt street-level bureaucrats to favor some clients over others (1980; see also Evans & Harris, 2004; Hjerne et al., 2010). But for most recent scholars writing from the so-called “street-level perspective” (Brodkin, 2008), discretion has been tacitly or explicitly treated as a necessary corrective to rigid and inflexible bureaucracies that are meant to, but often fail to, serve civilians adequately (Ellis, 2011). These scholars view discretion as a form of power: “frontline practitioners [...] translate institutional policy into daily, situated practice on the ground. This gives them great control and has considerable impact on institutions, as well as on the lives of the clients” (Hjerne et al., 2010, p. 303). As Prottas (1979) has noted, street-level bureaucrats are often the only ones who actually

⁴ See also Jeffrey Prottas (1979).

see what is happening in the front lines; their intimate knowledge of clients' lives makes them difficult to govern from afar.

How free, then, are frontline bureaucrats to act on their discretionary judgements? The recent rise of managerialism in public service bureaucracies has complicated such questions considerably. Has the new managerial order drastically reduced frontline discretion by dividing up functionaries' time into minute tasks and constant reporting? (Tsui & Cheung, 2004). Or are such conclusions premature? In an ongoing debate on this question, Tony Evans and John Harris (2004, p. 871) have sided more with the latter, arguing that the "death of discretion" has been greatly "exaggerated." An abundance of new rules, they claim, does not necessarily imply greater control, since autonomy will always remain in deciding *which* of the new rules to follow and in what manner. Others have concurred, observing that the rigor with which managerial expectations are enforced continues to vary from institution to institution (Prior & Barnes, 2011).

A related literature on so-called audit cultures (Harper, 2000; Power, 1997; Strathern, 2000; Shore & Wright, 2000) has also shed light upon discretion as the blind spot of auditing practices. In Western bureaucratic contexts, Michael Power (1997) observes, formal audit mechanisms have become an "intellectually attractive program" (1997, p. 8). Yet such mechanisms, he notes, are often fraught with failure: "audit documentation is only partly descriptive," he argues, of the intricacies that audits purport to uncover (1997, p. 37). There is a wide gap, in other words, between the "programmatic demands and expectations of auditing" and "its underlying operational capability" (p. 7). Part of this reflects the irreducible complexity of social life, and another, the specific ways in which audits are conducted.

Audits often display a curious circularity. Power notes, for example, that "[m]any audit reports communicate little more than the fact that an audit has been done" (1997, p. 13). The

fact that this happens so often, he continues, shows the degree to which audit practices are valued for their own sake. While this point may seem peculiar, it becomes easier to grasp once we understand audits as performances of accountability (Strathern, 2000). For Marilyn Strathern (2000), audit practices boast a ubiquitous social presence due to their ability to imply that things are being done correctly and honestly. Indeed, audits are so vital to establishing trust in bureaucracies that their form is sometimes valued over their substance to a degree that approaches religious zeal. In a nod to such connotations, Power refers to audits as “rituals of verification” (1997, p. 1).

The critical upshot of such analyses is that audit practices can deteriorate into the measurement of trivialities, rather than of key objects whose negative assessment might jeopardize an entire operation. Habitual verification, in other words, is vulnerable to exploitation by parties with an interest in organizational survival at any expense. This means that audits can be self-undermining, hollowing out their own purpose of weeding out ineffective or hazardous elements. Such arguments, then, imply a large discretionary space that exists beyond the reach of audit mechanisms. While audit scholars (Power, 1997; Strathern, 2000) do not devote themselves to the study of discretion per se as Lipsky (1980) does, their analysis would concur with his by explaining why daily practice often escapes the gaze of its auditors.

The fallibility of audit mechanisms would seem to predict organizational collapse. Yet some scholars have suggested that this is not necessarily the case (Meyer & Rowan, 1977; Orton & Weick, 1990; Rottenburg, 2009). For those who study organizational “loose coupling,” the limits of audit mechanisms have their advantages. Namely, partially decoupling representations from realities can help an organization get its work done, whether by circumventing an inefficient bureaucracy or by preventing scrutiny from undermining a project in its early days.

These scholars recognize managerialism as being unwieldy and ironically in need of its own restraints, which the “don’t, ask, don’t tell” workings of loose coupling can helpfully provide.

Loose coupling is a ubiquitous characteristic of bureaucracies, these scholars argue. In their view, organizations often tacitly tolerate some measure of it, and indeed, sometimes even strive to be “loosely coupled” even while paying formal lip service to rational governance. Drawing upon a similar language to Power’s (1997) “rituals” of verification, John Meyer and Brian Rowan (1977, p. 340) go as far as to suggest that “rationalized institutional rules” constitute but a “myth and ceremony,” concealing a lively array of loosely coupled cogs working busily underneath. Crucially, loose coupling as these scholars conceive of it is not merely a sign of corruption, but a basic requirement for organizations to function.

Certain forms of organizational deception, however, illustrate that there is but a fine line between loose coupling and sheer dysfunction. In their recent study of lying in the U.S. military, for example, Leonard Wong and Stephen J. Gerras (2015) observe that there are many more bureaucratic requirements in daily military practice than can be completed correctly. Nevertheless, full compliance is typically expected. Therefore, instead of acknowledging that time or resources are too scarce to complete particular tasks, military personnel often fake 100% compliance, euphemizing their deceit with terms like “making priorities” or “checking the box.”

As Wong and Gerras (2015) show, some level of deceit becomes normalized as an adaptive everyday practice, rather than a violation of trust that would undermine an organizational culture. While self-interested deception no doubt does exist, military officers do not see this particular form of deception as driven by personal gain. Instead, they see it as contributing to the common good by making vital tasks easier to complete, “restoring a sense of balance and sanity to the Army” (p. 20). Such rationalizations, Wong and Gerras acknowledge,

“softe[n] the sting of dishonesty” (p. 23). Higher-ranked military staff, meanwhile, often know they are being deceived. In many cases, “both those requesting information and those supplying it know that the information is questionable. Despite the existence of this mutually agreed deception, all concerned are content to sanction and support the illusion that all is well” (p. 12).

The ubiquity of this purported deception makes it difficult to believe that it can truly be as adaptive or mission-preserving as Lipsky’s (1980) discretion or Orton and Weick’s (1990) loose coupling are purported to be. Indeed, some of Wong and Gerras’ informants do express regret that minor lies are needed to make daily functioning possible. Meanwhile, the authors themselves worry that habitual lying at the scale they have uncovered may normalize or mask more malicious or self-interested deception. They conclude by calling on researchers to examine how organizations manage their internal tensions between deceit and truthfulness and between improvisation and order, and how they establish alternate mechanisms of trust in lieu of a universal presumption of obedience.

In sum, the studies I have described in this section have broadly converged on a core set of mutually reinforcing ideas: first, discretion by low-level bureaucrats is a necessary element of daily practice. Second, managers and supervisors often tolerate a certain measure of it despite frequent lip service to obedience and order. Finally, in this view, policy itself is therefore not rigidly conceived, but subject to frequent renegotiation, often with the knowledge of high-ranking actors.

Even though Lipsky (1980) focuses on discretion in service bureaucracies, and Wong and Gerras (2015) on widespread deceit in military settings (an arguably more extreme subversion), both studies, then, challenge popular assumptions about the need for organizations to be tightly monitored and controlled in order to function. “Loose coupling” scholars (Meyer & Rowan,

1977; Orton & Weick, 1990), meanwhile, have theorized why this might be the case. Coupling actions only loosely with their representations, they argue, serves as an important buffer against excessive scrutiny or unwieldy managerialism. As Wong and Gerras' (2015) study shows, however, important questions remain regarding how much loose coupling an organization could tolerate before widespread corruption or collapse would ensue.

COMMON INTERESTS AND OUTSTANDING QUESTIONS

The three literatures I have described so far – STS work on knowledge and order, aid and development studies, and organizational studies of audit and discretion – share an interest in how formal mechanisms of trust and accountability are created, sustained, and challenged. STS scholarship, for example, has shown how rationalization technologies become valued as governance technologies, and how they come to connote objectivity and transparency for diverse audiences. Audit scholars make similar arguments about bureaucratic formalism. While they question its ability to capture or control social life, they readily acknowledge its symbolic importance. As Pablo Yanguas, a political scientist writing on aid in sub-Saharan Africa, has put it, “formalism, impersonality, and written record in the exercise of public office are the fundamental norms governing state actors” (2012, p. 5). Even though these are ideals that do not exist in perfect form anywhere, he notes with some irony, they are still “the standard by which real bureaucracies are measured” (p. 6).

Critical scholarship on aid and development, meanwhile, has illuminated the specific stakes that audit processes might assume in aid settings. The increasing rationalization of the aid sphere, aid critics have argued, has the potential to devalue important interventions that are difficult to measure (Ebrahim, 2003; Ferguson, 1990; Stein, 2008). Admittedly, aid was not necessarily more recipient-driven before managerialism came along; yet managerialism, these

critics worry, may entrench donor-driven accountabilities by couching aid in a language of narrow consequentialism that clashes with long-standing traditions of humanitarian principles of humanity and unconditionality (Barnett & Weiss, 2008; Ebrahim, 2003; Stein, 2008).

Taken together, I argue, these three literatures offer up several important outstanding questions about humanitarian assistance. First, how do audit practices unfold in daily aid practice? Drawing more specifically on the idiom of coproduction (Jasanoff, 2004a), how do auditing and monitoring practices, as technologies of governance, change how aid interventions are understood and valued? And what are the limits of such audit practices? In other words, what can aid reports reveal about frontline practice, and what do they leave out?

Disorder and aid actors' awareness of it provide an important counterpoint to this first set of questions. Drawing on work on street-level bureaucrats (Barrett, 2004; Brodtkin, 2008; Lipsky, 1980) and loose coupling (Orton & Weick, 1990), we may ask how acts of discretion and improvisation arise in frontline aid practice in spite of efforts to minimize them. More specifically, how might contextual factors, like fluctuating funds or unpredictable needs, necessitate divergence from aid policies and mandates? What consequences might such divergences have for aid work? And what knowledge asymmetries might arise between frontline aid workers and donors as a result? Finally, how are notions of order and disorder themselves understood in such contexts? And how do aid actors reconcile appearances of disorder with formal expectations of rational action?

Several aid scholars have already begun to examine some of these questions. In his study of NGO governance in rural western India, for example, Alnoor Ebrahim (2003) observes that aid reports are often not meant to be representative of frontline practice. "Some information is collected only symbolically," he observes, arguing that its meaning "lies in the signals sent (to

funders for example) by gathering it, and not necessarily in using it in decision processes” (p. 96). Ebrahim also invokes the utility of loose coupling as a means of buffering aid practices from scrutiny by using reports to present a rule-abiding front to donors.

In his ethnography of development in Africa, Richard Rottenburg (2009) examines in greater detail the complex uses and meanings of loose coupling in development contexts. Donors and frontline aid workers alike, he argues, are constrained to follow two competing aid orthodoxies: a rational script and an emancipatory script. The rational script calls for efficient, systematic, rule-bound aid practices. Meanwhile, the emancipatory script, in a nod to a growing participatory aid orthodoxy, calls for aid actors to let recipients play a central role in deciding what they need, rather than determining their needs and solutions for them (see Leal, 2007; White, 2010).

In Rottenburg’s analysis (2009), the two scripts frequently contradict each other: the painstaking grassroots trust-building required by the emancipatory script is often too slow and politically fraught to satisfy the expectations of quick, transparent work of the rational script. In a sense, however, this contradiction is moot, as both scripts are partially fictional. In practice, Rottenburg argues in the most controversial part of his ethnography, patrimonial relationships and backroom deals are often ironically the most effective social glue between aid actors, and they operate in way that are neither “participatory” nor “rational.”

Such glue, however, Rottenburg emphasizes, is not merely a sign of failure or corruption, but rather helps aid workers complete projects, whether by circumventing unwieldy regulations or by avoiding ceaseless posturing. Yet it must often be hidden from scrutiny beneath a guise of rationality, embedded in a glut of “ritual evaluations [...] that will not call the system as a whole into question” (2009, p. 71). Reports and evaluations, in other words, become a cynical tool in

Rottenburg's account, seeming to evaluate efficacy while in reality serving to decoupling daily practice from its appearances.

Like Ebrahim (2003) and Rottenburg (2009), David Mosse (2004, 2005) also emphasizes the distance between aid policy and practice. Aid actors have been too preoccupied with designing better policies and not enough with how they are actually being implemented, he argues. In part, he blames the believers' and skeptics' camps for this: "Both the critical and the instrumental perspectives, then, divert attention from the complexity of policy as institutional practice" (2004, p. 644). A close examination of frontline practices, Mosse argues, often reveals that they are largely context-driven and have little to do with underlying policies. Nevertheless, he continues, "development projects work to maintain themselves as coherent policy ideas" in order to legitimize themselves, and policy documents are frequently adjusted ad-hoc to reflect the facts on the ground (p. 654).

While Mosse (2004), Ebrahim (2003) and Rottenburg (2009) present largely similar accounts of policy-practice gaps, Rottenburg and Ebrahim, unlike Mosse, emphasize that high-ranking actors are not as ignorant of these gaps as they might seem to be. For example, while Mosse's (2004) story appears to catch donors and policy makers unaware of the complex machinations transpiring beneath them, Rottenburg's account unveils a more sophisticated game: he shows how donors, consultants, contractors, and recipients all come to realize, each in their own ways, that frontline practice will not and cannot mirror policy declarations. They each subsequently engage in complex manoeuvrings to either compensate for or direct these divergences to suit their ends. Ebrahim (2003), meanwhile, alludes to a similar reflexivity by describing donor staff's growing weariness with reporting conventions (2003, p. 103).

My dissertation builds on these scholars' work on frontline discretion and ritualized evaluation by examining how such processes unfold in medical and psychosocial aid, primarily in Israel and Palestine. My work differs from theirs is not only in its ethnographic focus, but also in attempting a more detailed analysis of how improvisation and disorder arise in daily practice, and how they are understood and valued. In this respect, I find Rottenburg's (2009) argument regarding aid actors' tolerance of disorder to be particularly compelling. I focus on disorder and improvisation not simply to show that they exist, however, but rather to ask what work they do as part of aid workers' attempts to reconcile particular humanitarian tropes and mandates – unconditionality, universality and emergency – with daily contextual demands.

My overarching interest, as I indicated at the beginning, lies in how and why aid workers often idealize or strive for unconditional giving in spite of the considerable economic and political limits on their work, and in how they carry on with this work amidst significant contextual indeterminacy. Both foci pit humanitarian ideology, particularly its notions of purity, against the political intrigues and banalities of daily practice. As part of this, I seek to understand whether aspects of the humanitarian encounter that seem problematic from a planning standpoint – discretion, improvisation, and even failure – might paradoxically help to sustain aid work when rules become “an impediment to supervision” (Lipsky, 1980, p. 14).

DISSERTATION STRUCTURE

To examine forms of order and disorder in humanitarian assistance, I divide this dissertation into two seemingly disparate parts. The first two chapters, which are based on 11 months of ethnographic fieldwork, describe frontline medical aid practices at an Israeli NGO operating in Israel and Palestine. The third, fourth, and fifth chapters, meanwhile, undertake a significant shift in method, scale and theme, drawing primarily on semi-structured interviews

with psychosocial aid workers to examine policy-making efforts and aid governance in the global humanitarian mental health sphere. The dissertation's overall structure aims to show how notions of rationality and indeterminacy are understood and enacted both in the trenches (chapters 1 and 2) and far from them (chapters 3, 4 and 5).

The first two chapters illustrate how Israeli aid workers improvise medical assistance for Palestinian civilians living under military occupation and for sub-Saharan asylum seekers residing in Israel. Daily practice for these aid workers entails frequent failure and improvisation, as patient volumes typically exceed resources. But more importantly, it requires reconciling competing mandates: the more aid is given in the moment, the more likely it is that underlying inequalities will remain unaddressed. For this reason, long-term agendas like human rights advocacy typically call for less aid, even as many frontline aid workers call for more. By describing how aid workers juggle these competing short and long-term priorities while struggling to obtain treatments for patients, I show why it is so difficult – both ideologically and logistically – to subject frontline aid work to tight regimentation.

If the first half of the dissertation shows how aid indeterminacy arises, then the second half focuses on efforts to quell or at least monitor it from afar. Over the past two decades, mental health practitioners have been a growing presence in disaster and conflict zones. But their largely unregulated work, ranging from therapy to economic assistance and human rights advocacy, has drawn increasing alarm and criticism for its broadness, unknown efficacy, and the possibility of harm to recipients. Since the early 2000s, United Nations actors and NGOs have collaborated on policy documents to try and define and regulate this ambiguously bounded field. I examine these efforts from the perspectives of both policy makers and aid workers who would be expected to abide by such regulations. My main purpose is to understand how these actors

grapple with the challenges of defining psychosocial aid and carrying it out, and how they might turn to or reject managerialism as a possible solution.

This dissertation would likely have been easier to write if both its halves dealt with the same kind of aid, instead of two broad fields of practice with separate stakes and challenges. Access issues made this kind of unity impossible, necessitating some difficult stylistic choices. That said, the case studies I have chosen compensate for their disparity, I believe, by providing compelling sites for exploring aid indeterminacy and the challenges of coping with it. AHE, for example, is an organization in crisis, vacillating among competing humanitarian and human rights mandates (high aid in the moment, or lower aid combined with higher advocacy). These struggles accentuate the complexity of predicting and controlling frontline practice.

Meanwhile, psychosocial aid is a fairly new and contested field of practice. Critics have questioned its cultural suitability to non-Western aid settings: while the risk of cholera outbreaks is often beyond dispute in impoverished disaster zones, for example, it would be more challenging to argue that cholera sufferers also need psychotherapeutic treatment for depression. The field's ethics and boundaries of knowledge, in other words, are very much in flux, and have been vigorously critiqued and defended by insiders and outsiders alike. These debates, like the competing mandates at AHE, offer an important opportunity to observe policy work and aid governance in action. As both halves of this manuscript are devoted to such themes, they are, in a sense, not so different.

METHODS

A few years ago, I participated in a workshop that sought to bring together aid scholars and aid practitioners, two groups that, interestingly, rarely speak to each other or read each other's work. In advance of the workshop, several of the scholars sent around draft articles they

had written about their respective aid sites. The idea was for practitioners to read these articles and comment on how well they captured real-life aid work, and for the two groups to then engage in dialogue about the ethics and politics of humanitarianism.

One practitioner named Joanna de Berry, who was then a senior social development specialist at the World Bank and former academic, found the articles underwhelming. In her written response, she described feeling attacked by outsiders about issues that she knew about all too well. “I and many of my development and humanitarian colleagues are only too acutely aware of the moral dilemmas, the politics and the power relations of humanitarian intervention,”⁵ she wrote. “But the day-to-day reality of aid work is such that intervention involves a series of pragmatic decisions, compromises and trade-offs for the sake of on-the ground-action without the luxury of mulling over sophisticated academic dilemmas.”

None of our articles, de Berry continued, had done justice in her estimation to the compromises aid workers had to make in real life. “It is one thing for an academic to critique the unintended consequences of aid after the fact,” she wrote, “but a very different thing for an aid worker to have the foresight and resources to try and work out what those unintended consequences might be in advance, let alone how to mitigate them.” Her sharp words resonated powerfully with us, and made me much more circumspect about my arguments. I scratched out most of my early drafts and resolved to show, wherever I could, how aid actors themselves understood the ethical dilemmas and logistical constraints that undergirded their work.

In 2011 and 2012, I spent 11 months conducting ethnographic fieldwork at a small Israeli medical human rights NGO I call Activists for Health Equality, which caters primarily to Sudanese and Eritrean refugees residing in Israel, and to Palestinian civilians in the West Bank.

⁵ Jo de Berry’s words and name are produced here verbatim with her permission.

I usually spent three days a week at AHE, manning the door, registering patients and providing miscellaneous clerical assistance to patients and providers. I attended clinic meetings and staff meetings and spent many hours speaking with volunteers and paid workers – at the clinic, in cafes near the clinic, on buses, during car rides, and during medical excursions to the West Bank.

In addition to these numerous informal conversations, I conducted 22 semi-structured interviews in Hebrew with AHE volunteers and paid staff. Eighteen of these were tape-recorded and transcribed directly into English, with notable Hebrew words and phrases flagged in their original form in each transcript as reminders to return to the original recordings. In addition, to protect my informants' identities, their names, as well as the names of the NGOs in which I conducted my fieldwork, have all been replaced with pseudonyms.

From 2011 till 2013, I conducted over 70 semi-structured interviews with 55 different psychosocial aid actors: researchers who study the effects of psychosocial aid (based in Israel, the United States and the United Kingdom); consultants who had contributed to the 2007 guidelines and to other tracts of global mental health policy; and psychosocial practitioners who have worked in conflict, poverty, and disaster zones worldwide, including Haiti, Palestine, Israel, Poland, Kenya, Nigeria, China, and Chad (some researchers held secondary jobs as consultants, and some consultants had also been practitioners in the past).

Forty of these interviews were recorded, and of these recordings, twenty-five were transcribed in part or in full.⁶ With regard to the remaining unrecorded or un-transcribed interviews, notes were taken and used to inform the dissertation as a whole. Most interviews were conducted in person in Israel, the Palestinian Territories, the United States, and the United

⁶ Many of the interviews addressed a wider array of topics than I have had time to address in this dissertation. Some topics, and transcriptions, were therefore omitted due to space and focus considerations. Omitted interviews included the precise makeup of the IASC dissemination committees, or brief sketches of aid funding and research that lacked a broader context or a clear relationship with other issues of importance.

Kingdom, but some were conducted over Skype with practitioners in Ireland, Germany, Slovenia, Uganda, the Netherlands, India and the United States. My informants, most of them Americans and Europeans, had diverse professional backgrounds and levels of experience in psychiatry, psychology, non-profit work, social work, and humanitarian logistics and management. Some of my Israeli interviewees, moreover, were volunteers or employees at a psychosocial NGO I call Psychosocial Aid for Refugees (PAR), in which I volunteered and conducted some limited ethnographic observations for several weeks in summer of 2011.

The wide spread of my psychosocial interviews emerged almost accidentally. I had initially gone into the field intending to study the ways in which humanitarian psychology became politicized in Israel and Palestine. During my early interviews, however, I realized that for many of my informants, Israel and Palestine were just one aid stint among several. One informant, for instance, worked full-time as a therapist in Israel, but had also done cognitive behavioral work in post-tsunami Sri Lanka in 2005 and in post-earthquake Haiti in 2010. She then went on to found a small NGO in Nigeria. Other informants boasted similarly impressive CVs listing humanitarian missions to half a dozen or more countries, each lasting several weeks or months.

Mindful of the formidable cost and logistics of humanitarian travel, I was astonished to learn about these variegated careers. While some practitioners had joined the same NGO on different missions, many traveled with different organizations each time on a mix of soft NGO money and personal financing. As my astonishment subsided, I began to wonder what each of these brief missions amounted to in practitioners' eyes. What did they think they were up to in these short trips? What kinds of cultural training, if any, did they undergo before their arrival? What methods did they use, and how did they adapt them to each setting?

Examining their narratives without heading out to these sites myself, I realized, carried important risks. These were privileged Westerners who trod lightly on these territories themselves (Redfield, 2012). Speaking with them retrospectively might yield little but superficial and ill-informed vignettes, or worse, self-satisfied accounts of humanitarian “heroes” that left out much that was important about an aid setting’s local politics and history. Being so far from sites of action, moreover, could tempt me to frame needs and solutions in dichotomous terms of emergency/salvation and failure/success, while neglecting more ambiguous needs and outcomes. For these reasons, it did seem wiser to stay in one aid setting and see how different actors perceived what was going on, rather than to interview practitioners about their globe-trotting adventures.

At the same time, I was mindful that aid was rarely, if ever, “local,” but rather increasingly involved precisely those multiple yet fragmented sites, temporalities, and practices in which I was interested. Perhaps, I thought, I could transform part of my work into a second-hand multi-sited ethnography (Fisher, 1997; Marcus, 1995). My informants were ethnographic strangers in their professional habitats, hampered by unclear policies, limited funding, competing NGOs, locals’ suspicion, and their own cultural ignorance. However partial their own recollections might be, I thought, they might nevertheless yield an illuminating account of the indeterminacy and cultural strangeness that characterize many aid missions.

This is the path I ultimately took for chapters 3, 4, and 5. My work on Activists for Health Equality, meanwhile, also began largely accidentally. I began by interviewing their mental health volunteers about psychosocial work, without intending to study the organization as a whole. Soon, however, wanting to understand their work more deeply and curious about the drudgeries of daily aid work, I asked to volunteer there myself. Gradually, AHE presented a rich

opportunity for ethnographic fieldwork that I knew would never be possible with short-term psychosocial aid missions.

Following Udan Fernando and Dorothea Hilhorst (2006), I consider ethnography a useful tool of countering the temptation to frame aid work in terms of good/evil and success/failure binaries (Barnett, 2005). The aid literature has often been prone to such broad pronouncements, as indeed has the aid industry itself, speaking of aid as either transformative or as preserving the status quo, as either beneficial or harmful, and as respectful of local knowledge or as dismissive of it (Barnett & Weiss, 2008; Maren, 1997; Terry, 2002). Throughout the dissertation, I work hard not to reduce my narrative to that of wise frontline aid workers resisting the tyrannical dictates of far-away policy makers, or of disaster-struck populations being trampled by their self-styled saviors. Instead, I attempt to show the doubts, debates and deliberations that accompany aid decisions, and to draw out different aid actors' own reflexivity and ambivalence about them wherever possible. When such binaries do appear, I attempt to examine them critically and illustrate the work that they do in reinforcing desired visions of humanitarian work to particular audiences.

OUTLINE

I begin the dissertation with a study of humanitarian improvisation. In chapter 1, I examine how AHE volunteers and paid workers try to obtain medical treatments for non-citizen patients without health insurance – primarily asylum seekers from Sudan and Eritrea. Such negotiations, I show, involve soliciting donations and negotiating semi-secret discounts within the state's medical system, in which many of AHE's aid workers themselves work. Hinging as they do on fluctuating compassion and resources, such treatments are often failure-prone and unpredictable. By illustrating how aid workers struggle to channel state resources for

humanitarian ends, I question commonly assumed distinctions between informal charity and formal channels of care.

In chapter 2, I describe AHE's efforts to reconcile human rights and humanitarian agendas. Aid workers treat patients while lobbying the Israeli government to assume long-term responsibility for them. Each healed patient, therefore, they realize, contributes in some way to a weaker advocacy case. I argue that while both humanitarian relief and human rights advocacy, as responses to injustice, are informed by ideals of universality and humanity that see every person as equally deserving of care regardless of their race or country of origin, the practice of both aid and advocacy is deeply concerned with questions of conditional worth and of who is more and less deserving of care, resulting in a complex moral economy that prioritizes some aid recipients while neglecting others. In addition, I argue, permissive approaches to improvisation and even failure at AHE complicate prevalent assumptions about the need for humanitarian assistance to be tightly governed and controlled in order to function.

Chapters 3 and 4 shift to peripatetic psychosocial aid. In chapter 3, I examine efforts by UN actors and NGOs to produce "best practices" guidelines on humanitarian mental healthcare. The resulting 181-page 2007 document, I argue, presents an interesting contradiction: it promises to make the field both more "sustainable" and recipient-driven, on the one hand, and more rigorous and evidence-based, on the other. Examining how and why these dual prescriptions clash, I then situate the guidelines within long-standing debates about the cross-cultural applicability of Western psychotherapy (Kienzler, 2008). I show that while some practitioners take for granted the universality of categories like post-traumatic stress disorder, others treat "psychosocial" merely as a convenient catch-all term for a wide range of interventions that implies no particular methodological commitments.

In chapter 4, I suggest that the UN mental health guidelines constitute an important aspirational document and a proxy for aid actors' anxieties about aid efficacy and rationalization. Notwithstanding the guidelines' call for greater rigor and systematicity, they surprisingly contain very few specific recommendations for actual practice. Reading this omission as a tacit acknowledgement of the need to preserve discretion in the front lines, I seek to understand how such reflexivity might emerge and juxtapose it with ongoing debates about the meaning of psychosocial evidence, sustainability, and cross-cultural applicability.

Chapter 5 concludes the dissertation with an expanded discussion of aid rationalization. I focus on logical frameworks or logframes, a quantitative reporting tool that is increasingly common among aid organizations and donors. Drawing on interviews with practitioners and on ethnographic vignettes, I describe interventions that are difficult to measure and codify using logframes. I then illustrate frontline aid workers' own doubts about managerialism, describing how they resist logical frameworks while preserving a space for discretionary action, and noting where they fail to do so. I conclude by suggesting that higher-ranking aid actors are possibly as skeptical as are frontline functionaries about whether aid rationalization is possible, as well as about whether it would be a good idea.

Aid organizations often paint humanitarianism as a space apart, a zone of exception that ignores political affiliations and gives life-saving assistance to all persons irrespective of their origins (Barnett & Stein, 2012; Barnett & Weiss, 2008, 2011). In such portrayals, there is a hushed deference to notions of purity and unconditional giving. How might such ideals be reconciled with quantitative benchmarks? Such benchmarks have redefined good aid and created new funding conditionalities. They have transformed relations among donors, aid workers and recipients into more business-like interactions that seems a far cry of sweeping narratives of

salvation. Such narratives, however, remain cherished by many aid workers, and as I will show, continue to manifest in important ways in their daily work.

CHAPTER 1

HUMANITARIANISM ALONG STATE MARGINS⁷

On a rainy February morning in 2012, Adí and Uri, two aid volunteers, were poring over medical files inside the offices of Activists for Health Equality (AHE), a medical NGO in Jaffa, a mixed Jewish-Palestinian port city just south of Tel Aviv. Situated about half a kilometer from the Mediterranean coast, AHE's lackluster concrete exterior, sparse windows, and trash-strewn entrance gave little indication of the nature of the activity inside. A stranger walking past the building would be surprised to learn that this NGO was the country's main healthcare hub for tens of thousands of uninsured migrant workers and asylum seekers, for whom governmental medical institutions were largely off-limits.

AHE's free medical clinic generally opened for walk-ins from 4 p.m. to 9 p.m. During those hours, the atmosphere both inside and outside was noisy and chaotic: the waiting room was cramped, and there was no organized entry system for patients. Begging, pushing, and circulating haphazardly written sign-up sheets often became the *de facto* means of asserting one's place in line. In the mornings, however, the atmosphere was still calm. The street outside was still largely empty and silent, and inside, a handful of morning volunteers were busy negotiating discounts with local hospitals and calling patients to inquire about their ability to pay for procedures.

On this particular February morning, Adí and Uri sat in one of the treatment rooms, leafing grimly through a thick pile of dog-eared patient files. These contained dozens of referrals for expensive secondary care that would probably never be carried out. Primary care was

⁷ Partial versions of this chapter have been published in Benjamin, I. (2015). "Medical NGOs in Strong States: Working the Margins of the Israeli Medical Bureaucracy." In Abramowitz, S. & Panter-Brick, C. (Eds.), *Medical Humanitarianism in States of Emergency*. Philadelphia, PA: University of Pennsylvania Press.

provided onsite by volunteers at AHE's free medical clinic, but secondary and specialized care posed a persistent economic problem. AHE had a modest budget for some treatments, medications, and tests, donated by the United Nations High Commissioner for Refugees, the European Commission, and European NGOs and governments. But most specialized care exceeded this budget and had to be quietly negotiated in the form of donations or discounts with local practitioners and hospitals. Since many such negotiations failed, it was in AHE's interest to prevent such expenses in advance by improvising the cheapest tests and treatments available.

Many of AHE's primary care volunteers, however, were not aware of these constraints. For most of its physicians, nurses, and medical students, AHE shifts were a sporadic volunteer stint alongside a full-time day job in a government hospital or clinic. Two or three times a month, they drove or biked down to AHE's clinic after work to complete a second pro-bono shift with patients whom they would otherwise never see. Despite being a self-selecting group of practitioners who were deeply sympathetic to the plight of migrants, the specifics of the latter's political precariousness often eluded them. For example, they often unwittingly recommended the same tests and specialist consultations that they did with Israeli citizens, not realizing that asylum seekers and illegal migrant workers could not be routed through the governmental healthcare system.

To avoid a glut of patients waiting for treatments that they could neither access nor afford, Adí and Uri would come in and "sit on files," or improvise cheaper alternatives, whenever possible, to these misguided "first world medicine" referrals. An indefatigable internal medicine physician in her mid-seventies, Adí was by now mostly retired and had the time to do this, while Uri, still in his twenties, was a part-time philosophy graduate student and part-time employee in his family's business. Volunteers in nearby rooms often heard them venting

together about light-on-the-trigger referrals. “Someone has a skin problem and they make a referral to a skin doctor!” Adí said on this February morning with a mix of incredulity, frustration and humor. “It ties up a precious appointment. *Why?* There are so many reasons for a skin problem that a skin doctor needn’t bother with!” She scratched out the referral in frustration.

AHE did often have a dermatologist or two on its volunteer rolls, but like other specialists, they offered only a few pro bono slots per month. While Adí found pleasure in the medical challenge of improvising alternatives, its broader context of exclusion saddened her. “This is a humanitarian clinic, not a governmental hospital; what are they expecting [us to be able to do]?” she was often heard morosely rebuking absent colleagues.

On this cold February morning, they soon came upon a chest x-ray referral for an asylum seeker with a suspected broken rib. This patient was lucky, they chuckled, that his rib was the problem. Crossing out his referral, Adí redirected him to a governmental tuberculosis clinic, scrawling “suspected tuberculosis” on the referral sheet. She did not suspect tuberculosis, but as a public health policy, Israel’s Ministry of Health offered free tuberculosis testing to anyone who asked, citizen or not. A chest x-ray from a tuberculosis clinic, Adí knew, would do just as well for a broken rib. They had used this loophole numerous times, avoiding suspicion in part because their patient population had a higher rate of tuberculosis than Israel’s general population. But other types of fractures proved more difficult to handle. A few minutes later, for instance, Udi came across a file for a patient with a suspected broken wrist. It was a shame, he joked to Adí, that this new patient couldn’t go to the TB clinic under the same pretext and stick his wrist in the x-ray machine during the chest exam.

Founded in 1998, the free clinic had begun as AHE's primary care response to a dearth in affordable healthcare for uninsured patients in a country whose comprehensive single-payer system was, and still is, limited almost exclusively to citizens. The clinic had no formal opening day; it was a gradual, largely improvised initiative whose first patients were primarily migrant workers from south-east Asia. In the early days, "it was not clear whom you would treat and whom you would not treat," one of the clinic's founders, a gynecologist, recalled in 2012. "There were no guidelines," and little planning for anything beyond primary care. Back then, he remembered, volunteers never discussed, and barely even imagined, what they would do if a cancer-stricken undocumented migrant walked into the clinic.

By 2011, in contrast, the clinic's practices had evolved into an intricate web of arrangements for obtaining specialized treatments and examinations of all kinds, whether through donations or through semi-secret discounts in governmental institutions. This web spanned hundreds of physicians and dozens of hospitals, creating the illusion of regularity despite its absence of guarantees or stable bureaucratic channels. Falsely claiming suspected tuberculosis, for example, habitually saved patients several hundred shekels per x-ray. Thus, navigating the boundary between one-time favors and steady loopholes like free tuberculosis tests became a daily challenge for AHE's aid workers.

In this chapter, I use the case of AHE and Israel's population of roughly 50,000 sub-Saharan asylum seekers to show how aid workers improvise medical services for populations excluded from government-sponsored healthcare. I argue that in Israel, this process involves neither creating a parallel healthcare system nor simply diverting governmental resources in secret. Rather, this non-governmental aid requires a complex mix of opaque and transparent alliances and agreements between NGO staff and governmental actors.

IMPROVISED MEDICINE

Emergency cases were not a problem for AHE aid workers. Adí and her colleagues knew well that acute conditions, like stab wounds or broken limbs, could be immediately routed to governmental hospitals' emergency rooms, which were required by law to treat them immediately (Filc, 2009). But many life-threatening conditions like heart disease and cancer were generally not considered emergencies. Uninsured non-citizens who suffered from them were therefore turned away from governmental institutions unless they proved they could pay out of pocket for treatment – which virtually none of them could.

AHE's primary challenge, therefore, was to somehow obtain treatment for “complex” patients who did not qualify for emergency governmental care. Since AHE's budget fell far short of financing 2,000 shekel MRIs or 20,000 shekel heart surgeries, its aid workers and volunteers appealed instead to the mercy of their colleagues and acquaintances, trying to construct chains of care held together by acts of compassion, not legal entitlement or economic contracts. Sometimes a chain came together in a matter of days, but more often, patients remained stuck in limbo for months or even years. For a patient needing heart surgery, for example, several elements had to fall into place at once: a cardiologist had to agree to take the patient pro-bono; a surgeon needed to donate four hours of her time; a corporate representative had to waive the cost of the stents; and a hospital bureaucrat had to be persuaded to quietly approve the use of an operating room. Hospital policies and bureaucratic structures often had to be delicately contravened and rearranged.

AHE's unpredictable successes and failures created a shroud of habitual uncertainty for aid workers and patients. Some medication shipments and hospital discounts became so regular that aid workers came to see them as guaranteed. But most others were so unpredictable that

overall, AHE aid workers never knew in advance how many patients, or which conditions, they could to treat in any given month.

In a sense, AHE's arrangements were not so tenuous. Its most extraordinary advantage was the fact that most of its volunteers were employed in the governmental system. It was their invaluable connections in it, therefore, that made many specialized treatments possible. At the same time, a humanitarian infrastructure of this sort was highly unstable: donations and volunteers fluctuated frequently, and managers had little ability to oversee or predict aid activity in detail or in advance (i.e., how many patients would be treated, what illnesses would be treated).

The obvious foil to AHE's medical practices was the relative stability and comprehensiveness that its volunteers often ascribed to governmental hospitals. Yet even while lamenting the instability of the medicine they practiced at AHE, most aid workers did not want AHE to become a governmental clinic, or even to resemble one; there was an important resistance within AHE to regularizing or bureaucratizing its services. In other words, the same ambiguity that aid workers frequently decried was, in subtle ways, valued and preserved through other forms of inaction. In the following pages, I try to explain this paradox. As I will argue, the organization's ambiguous policy on aid and its often chaotic modes of work were not simply symptoms of organizational malaise: rather, they served important roles in fashioning and maintaining its oppositional activist identity.

THERAPEUTIC ITINERARIES

Falsely claiming suspected tuberculosis in order to obtain a free chest x-ray may seem extraordinary to those familiar primarily with how medicine appears to work in sophisticated medical bureaucracies. But on a global scale, such improvisation is the norm (Nguyen, 2005).

Indeed, the term “improvised medicine” implies it is a rare deviation from a stable bureaucratic order. In reality, however, such order is largely reserved to countries fortunate enough to possess efficient, protocol-governed medical bureaucracies, and even then, to a select group of patients within them.

Anthropologists of medicine have long been interested in the indeterminacy that accompanies diverse forms of healing. Vinh-Kim Nguyen defines such “therapeutic itineraries” as “heterogeneous and uneven congerie[s] of practices and techniques” that people undertake in an effort to secure medical and healing treatments for themselves and others (2005:126). For example, in Helle Samuelson’s (2004) account of medicine in rural Burkina Faso, villagers obtain treatments through a mixture of local healers, diviners, herbalists and marketplace peddlers of Western pharmaceuticals, leaving governmental clinics largely empty.

In the occupied Palestinian West Bank, meanwhile, residents in search of specialized treatments have had to negotiate a sporadically coordinated array of private medical clinics, NGOs, local civil society organizations, Palestinian Authority hospitals, and hospitals run by the United Nations Relief and Works Agency (Schoenbaum et al., 2005). Yet such improvisation is not limited to weak or non-state settings; in the United States, for example, medical practitioners regularly seek bureaucratic and policy loopholes in an effort to make treatments accessible, or tweak diagnoses when possible so that insurance companies will pay for the treatment (Horton, 2006). Thus, we might consider bureaucratic efficiency and flexibility as existing on a continuum, with workable margins and loosely connected parts being found in every bureaucracy.⁸

⁸ Whether the improvisation and bureaucratic flexibility that are often seen as conditions for successful humanitarian medicine are different in kind or in degree from the porousness of medical bureaucracies in developed states, remains an open question that is likely highly dependent on context. See pages 72-73 for a discussion of the blurry distinction between governmental and non-governmental channels of care.

While a lot of medicine happens outside formal state channels, then, aid organizations that take over such responsibilities temporarily often find themselves doing so indefinitely. This dilemma has been widely referred to as the “double bind” problem (Redfield, 2012a), the “fig leaf” problem (Castañeda, 2011) or the “gap-filling” problem (Lorgen, 1998). For example, Heide Castañeda (2011) illustrates how German doctors caring for an undocumented population residing in Germany realize over time that their work is not a temporary exception, but rather an indefinite replacement for the governmental system. In Israel, Sarah Willen (2011, 2012) and Gottlieb et al. (2012) have likewise illustrated the struggles of Israeli medical practitioners who care for asylum seekers outside state medical channels. While some fear that doing so will encourage the Israeli government to turn a blind eye to asylum seekers’ plight, others counter that sick and dying people should not have to wait in vain for the Israeli government to change its policies.

These scholars have done important work elucidating the dilemmas of humanitarian medicine in strong states. Yet relatively little is known about how treatments are negotiated in daily practice. I seek to fill some of this gap by showing, in AHE’s case, what requests, alliances, decisions, and loopholes this work entails. As I will show, the treatment of complex and chronic illnesses often involves collaborations with government actors that fall under what Michael Taussig (1999) has called a “public secret” – that which many people know about but are hesitant to articulate in public spheres. Collaborations among AHE and government actors, I argue, blur the distinction between official and unofficial channels of care, and between charity-based and citizenship-based grounds for treatment.

ASYLUM SEEKERS IN ISRAEL

Since 2006, an estimated 50,000 asylum seekers have arrived in Israel, a country of just over 8 million, through the Sinai desert (Fezehai, 2014; Harris, 2013; Lior, 2015).⁹ Most asylum seekers have been Sudanese and Eritreans fleeing ongoing ethnic violence in Sudan, and indefinite conscription and extra-judicial executions in Eritrea. Israel is a signatory to the 1951 United Nations Convention relating to the Status of Refugees (henceforth the 1951 convention). This international legal instrument behooves signatory countries to adjudicate the asylum pleas of individuals claiming to have fled their countries of origin due to persecution, and to grant them asylum if they appear to be telling the truth.

Yet despite Israel's nominal allegiance to the 1951 convention, the Israeli Ministry of Interior's approach to asylum seekers has largely mirrored its Jewish-centric migration policy: granting Jews the right to immigrate to Israel whilst effectively denying this opportunity to most non-Jews (Darom, 2013).¹⁰ In August of 2011, then-Minister of Interior Eli Yishai made no

⁹ The precise numbers are contested, because both official definitions of "refugees" and "asylum seekers" and the counting methods themselves are multiple and subject to considerable debate, with different actors periodically inflating and deflating these numbers to serve different agendas. The Israeli government, for example, has declared its interest in presenting most asylum seekers as economic migrants, not "genuine" refugees fleeing persecution, and in some settings has denied them the moniker "asylum seeker" altogether. Accordingly, some governmental and media representations have presented much lower numbers for the asylum seeker category than 50,000. In other cases, some media reports will do the opposite, lumping asylum seekers in with a larger group of presumed economic migrants and reporting numbers exceeding 100,000, presumably in a dual effort to attributing economic motives to sub-Saharan migrants and to evoke xenophobic sentiments within the Israeli public (a complicating factor here is that tens of thousands of additional undocumented migrants residing in Israel hail from dozens of countries worldwide and make no claims to having fled persecution; Omer-Man, 2014). In contrast, some governmental and media reports do appear to remain rather agnostic regarding the meaning of asylum seeker, and will report relatively high numbers (50,000-60,000), but without appearing to confer upon these migrants the legitimizing moniker of "refugees," implying that this is a category which needs to be officially bestowed upon a person by a higher authority (e.g. the United Nations Higher Commissioner for Refugees or the Israeli Ministry of Interior). Finally, some NGOs working on behalf of asylum seekers have often used "asylum seeker" and "refugee" interchangeably, presumably a declaration of faith in the genuineness of their beneficiaries' flight from harm. As of May 28, 2016, the African Refugees Development Center, a prominent NGO based in Tel Aviv, reports 46,437 asylum seekers, 73% of whom are from Eritrea and 19% percent of whom are from Sudan (ARDC, 2016).

¹⁰ An investigation by Darom (2013) shows that Israel's Ministry of Interior has to date lacked a clear policy regarding non-Jewish migration into Israel. While Jewish migrants often obtain near-automatic Israeli citizenship upon arrival in Israel, non-Jewish spouses and other relatives of Israeli citizens who make an effort to regularize their status in Israel can expect years, and in some cases decades, of bureaucratic foot-dragging and ethnic profiling.

secret of his personal dislike for asylum seekers, particularly Muslims from Sudan.

Characterizing them as deceitful “infiltrators” and an “existential threat to the Jewish state,” he declared that if he could not deport them, then he would “lock them up to make their lives miserable” (Human Rights Watch, 2014, p. 21, 5).

Ministry of Interior policies since then have largely reflected Yishai’s view. At the time of my fieldwork (2011-2012), Israeli authorities worked hard to detain, govern, and whenever possible, deport their new arrivals. After crossing the Israel-Egypt border by foot,¹¹ asylum seekers were typically met by the Israeli army, briefly detained and registered in holding facilities, and then given temporary non-deportation documents known as conditional release visas, which carried no healthcare rights or work permits. At this point, most were given one-way bus tickets to Beer Sheva or Tel Aviv, where they joined up with their fellow countrymen, often sleeping at first in public parks or, for those more fortunate, in cramped tenement apartments in south Tel Aviv.

Gradually, as migrant populations tend to do, able-bodied asylum seekers began to fill Israel’s high demand for under-the-table employment in construction, cleaning, and agriculture. Meanwhile, several thousand more moved to the southern coastal city of Eilat to work in the hospitality industry. In this manner, a population of tens of thousands gradually amassed even as Israeli officials scrambled to devise policies and restrictions that would limit and punish their presence in the country.

The main thrust of such policies has been denial of asylum applications and sporadic detainment meant to keep asylum seekers in a constant state of fear and vigilance. To date, Israel’s Ministry of Interior has rejected more than 99.9% of sub-Saharan asylum seekers’

¹¹ Hundreds of cases of torture, abduction and ransoming of sub-Saharan migrants and asylum seekers have been documented in the Sinai desert since 2006 (Lynch, 2012).

asylum applications (Human Rights Watch, 2014, p. 8). Israeli government statistics indicate that as of February 2015, of 3,165 Sudanese asylum applications, none have been recognized as refugees, and 2,200 cases were still undecided. Of 2,408 Eritrean asylum claims, only 4 were granted, over 1,000 have been denied and 1,335 were still undecided (Lior, 2015).¹²

As Israel's asylum seeker population has grown, governmental policies have accordingly become both more punishing, meant to double as a deterrent against future asylum seekers (Kritzman-Amir, 2012). For example, asylum applications have typically been kept in limbo for years, stay visas are revoked without warning, and thousands of asylum seekers are imprisoned without trial in detention centers in the Negev desert (Kershner, 2013; Kestler-D'Amours, 2013). Opaque and inconsistent policies have also been the norm regarding where asylum seekers have been permitted to live in Israel, how and where they could renew their visas, and whether their employers would be fined for hiring them without a work permit (Guarnieri, 2012).¹³

In violation of the 1951 convention principle of non-refoulement, which prohibits the deportation of asylum seekers before their asylum claims have been adjudicated, the Israeli government has forcibly returned dozens of asylum seekers to return to the Egypt-controlled Sinai desert within hours or days of their arrival (Kritzman-Amir & Spijkerboer, 2013). Others, meanwhile, have been pressured to leave Israel "voluntarily" on threat of indefinite detention in Israel's Negev desert (Kestler-D'Amours, 2014), or deported to third countries such as Rwanda

¹² These numbers seem perplexingly low in comparison with the tens of thousands of asylum seekers residing in Israel. Many have not formally lodged asylum claims, and many have not been reviewed, but the numbers cited here still appear low.

¹³ Tens of thousands of asylum seekers do work in Israel without a permit, often paid in cash every night for day-by-day jobs in cleaning or construction. Israeli authorities have generally refrained from sanctioning their Israeli employers despite repeated threats to do so. As a result, asylum seekers have largely remained vulnerable to exploitation by their employers, which few are willing to report owing to fear of deportation (Lior, 2014; Michaeli, 2012).

and Uganda, where they faced the prospect of abduction, imprisonment, torture and further deportation (Human Rights Watch, 2014; Omer-Man, 2014).

Israel's asylum policies have elicited a public outcry in the Israeli political left and in the global human rights community. But the majority opinion in Israel has expressed little sympathy for asylum seekers, mirroring a rightward shift in Israeli politics. Dominant political voices in Israel have characterized all or nearly all asylum seekers as economic migrants masquerading as refugees who should be expelled from the country, or at most, permitted to stay with minimal rights in order to avoid attracting international criticism (Omer-Man, 2014). In low-income urban areas populated by large numbers of asylum seekers, such sentiments have periodically ignited into bursts of mob violence against asylum seekers. Meanwhile, a number of Israeli right-of-center politicians have fanned such xenophobic sentiments with alarmist rhetoric about Israel being imminently overrun by hundreds of millions of infiltrators from sub-Saharan Africa (Human Rights Watch, 2014).

A fence hastily built along the Israeli-Egyptian border in late 2012 effectively put an end to the flow of new asylum seekers from the Sinai, reducing the number of entries into Israel from over 10,000 in 2012 to just 43 in 2013 (Omer-Man, 2014). This abrupt change took by surprise many NGO workers and volunteers, who had often voiced skepticism that a mere fence could stop the flow of asylum seekers. Once it did, their main concerns gradually shifted from providing for an ever-growing stream of new asylum seekers, to providing for the tens of thousands already present and advocating for their release from indefinite detention.

ACTIVISTS FOR HEALTH EQUALITY

Activists for Health Equality (AHE) was founded in 1988, shortly after the beginning of the first Palestinian Intifada. Intifada, an Arabic word often translated as “shaking off,” denotes

the commencement in December 1987 of widespread, largely grassroots-driven Palestinian protests of Israel's military and civilian occupation of the West Bank and Gaza, which had begun in 1967. AHE's founders, most of them Israeli Jewish physicians identified with Israel's political left, sought to express solidarity with Palestinian victims of Israeli state violence by carrying out short-term medical missions to West Bank villages, where access to medical care was limited. Over time, AHE broadened its mandate to include asylum seekers and undocumented migrant workers, viewing Israel's military occupation and draconian asylum policies as reflecting the same conservative, Jewish-centric political ideology.

Since 1995, the Israeli government has overseen a single-payer, taxation based healthcare system that provides heavily subsidized medical coverage to Israeli citizens (Filc, 2009). AHE has called on the Israeli government to extend similar provisions to impoverished non-citizens living in Israel, while promoting a view of healthcare as a universal human right (Willen, 2011, 2012). Other political campaigns have been broader in scope, drawing attention to the public health effects of the occupation, such as the contamination of Palestinian drinking water by waste flowing from Jewish settlements situated on hilltops.

These campaigns have seen limited success. During my fieldwork, asylum seekers were still excluded from most forms of government-subsidized primary and secondary care.¹⁴ Meanwhile, AHE acquired a reputation for left-wing radicalism, and was often accused in center-right circles of siding with enemies of the state. Israeli taxi dispatchers, for example, periodically refused to send taxis to AHE's clinic to transport urgently ill asylum seekers to local

¹⁴ Some forms of care were gradually made more accessible: for example, AHE had helped negotiate subsidized health insurance for asylum seekers' children at a cost of only a couple hundred shekels per month. But as many AHE volunteers reported, it became difficult to persuade parents to sign their children up and pay these premiums.

hospitals. They either hung up the phone after hearing AHE's address, or openly berated AHE for encouraging asylum seekers to come to Israel.

Following Israel's 1996 Patient's Rights Act, public hospitals have been required by law to treat any person in immediate danger to life or limb (Filc, 2009). But reality has not always mirrored this policy. On numerous occasions, asylum seekers have been deterred from seeking emergency care by hospital receptionists demanding payment upfront or by the sight of hospital guards, whose uniforms resemble those of police and immigration officers. Non-emergency conditions, meanwhile, as I have mentioned, cannot be routed to governmental hospitals unless death was imminent. In the following section, I explain in detail how AHE aid workers attempted to circumvent this policy and to negotiate the compassion-based chains of care to which I alluded near the beginning of this chapter.

SNEAKING PATIENTS INTO EMERGENCY ROOMS

In 2011, a young Eritrean asylum seeker arrived at the clinic with a malignant brain tumor. Unaccustomed to seeing cancer in this young, relatively healthy population, AHE volunteers were at a loss. A discounted brain scan had made this diagnosis possible, but surgery and chemotherapy both presented costs of a different order of magnitude. A malignant brain tumor, in and of itself, would not count in the eyes of hospital bureaucrats as an emergency condition; otherwise, AHE would have referred the young man to a local hospital, knowing that the bill would come after treatment and not stand in the way of this man's immediate survival. Undeterred, Sandra, an energetic volunteer oncologist in her thirties, began calling every oncologist she knew. Eventually, she was fortunate enough to locate a sympathetic colleague at a nearby hospital. Hearing of the patient, he agreed to tell his superiors that the man was suffering from intracranial bleeding, an emergency diagnosis certain to satisfy any hospital

bureaucrat. Recounting the story to me a year later, Sandra spoke casually of this lie as belonging to a genre of social misrepresentation widely termed *combinot*.

The plural of *combina*, a colloquial Latin-derived Hebrew expression, *combinot* denotes both *connections* and the creative bending of rules in a personally beneficial way. One who seeks faster processing times for his passport through a friend who works at the Ministry of Interior, for example, is trying to “get” or “do” a *combina*; those who possess friends in high places can boast that they “*have* a *combina*.” It is an obviously universal phenomenon: writing of socialist Poland, Elizabeth Dunn (2000) calls connections “the social pillar upon which state socialism rested” (p. 73). Yet in Israel, the particular forms that *combinot* take are nevertheless invested with a local flavor by many Israelis, for whom norms of long-term reciprocity among friends, relatives, colleagues, and erstwhile army comrades are often compelling and difficult to refuse.¹⁵

Combinot are widely and sometimes cynically invoked as necessary to some degree for advancement in work and politics. Even strong critics of the widespread patrimonialism in Israel’s public and private sectors will acknowledge that everyone must play this game on occasion. Although term *combina* is regularly invoked euphemistically to hint at a corrupt practice, then, the same term can also be used to soften or deflect accusations of corruption by normalizing or downplaying one’s activities as mere *combinot* of the sort that many civilians depend on for daily survival.

¹⁵ There are equivalents of “*combinot*” in every language. In Elisabeth Dunn’s (2004) ethnography of Polish factory workers’ transition from socialism to capitalism, the term *znajomości* is used extensively to describe how factory workers relied on “personal connections” (*znajomości*) for economic survival and workplace advancement in a socialist (and later, in a capitalist) economy. In Brkovic’s (2014) discussion of humanitarianism in a Bosnian town, the term is *veze*. In Dunn’s work, *znajomości* are often explicitly differentiated by their users from corruption, to avoid the uniform negativity that an automatic association between corruption and *znajomości* would bestow upon a practice so necessary for everyday survival. Some AHE volunteers felt similarly about *combinot*.

In Sandra's view, however, the *combina* at the emergency room was of a different kind altogether: an altruistic complicity among practitioners and bureaucrats. As she put it,

... the lie is never between a doctor and doctor. The lie is a tiny lie in the entry to reception. Again, this is a patient who without surgery *would* eventually become emergency-room-worthy, but [using this excuse] we could prevent metastasis and help save his life. The administrators often understand this, but the government and the Ministry of Health don't understand this. It requires basic cooperation between people. Everyone knows the name of the game and plays it.

Although she spoke with a confidence suggesting many years of successful *combinot*, Sandra's first successful case had in fact occurred only a couple years earlier. Isaac, an Eritrean asylum seeker in his early twenties, had arrived at the clinic with a diagnosis of lymphoma from a local hospital. The hospital had likely admitted him for a related emergency, she speculated, and then discharged him when the lymphoma was discovered.

Isaac was a quiet but engaging young man. "I sat there in front of this young man who didn't speak one word of Hebrew or English, with a deadly disease that could be treated," she recalled. "What do we do? We don't have a function that treats expensive patients in the clinic." She took Isaac's diagnosis letter to a hematologist at her hospital, who, to her surprise, simply said, "let's give him in one round of chemo and see what happens."

Mindful that hospital bureaucrats might stand in the way of "one round of chemo," Sandra and her colleague told intake receptionists that Isaac had trouble breathing due to his neck tumor. It was not true, Sandra said, but was plausible enough given his condition that no one asked questions. Isaac was hospitalized and given the first round of chemo the next morning. "No one at the administration realized that anything had happened," she added. From then on, things moved rapidly. Sandra was fortunate enough to find a sympathetic, well-heeled acquaintance – incidentally, the manager of a medical tourism business – who agreed to pay for Isaac's remaining chemotherapy treatments, totaling some 14,000 shekels. This stroke of luck

solved the problem of having to hide future sessions of chemotherapy – which would not be considered emergency treatment – from bureaucratic scrutiny.

For Sandra and for other volunteers, personal and humanitarian realms soon blurred when Isaac stopped showing up for treatments. It was unclear whether he failed to understand the severity of his condition or was simply struggling to cope with the harsh physical effects of chemotherapy. Refusing to let him disappear, another AHE volunteer began to seek Isaac out on a daily basis and accompany him to the hospital along with an interpreter. Sandra, meanwhile, set herself phone reminders to call Isaac in advance of each chemotherapy session, telling him “I am warning you, if you don’t show up next time...”

It helped, Sandra conceded, that Isaac was such a charming fellow. Volunteers forgave him his absences and spent many hours trying to help him with transportation, translation, and basic necessities like food and shelter. Possessed by a near-messianic fervor, some of them became convinced that with his limited Hebrew, and his lack of familiarity with the Israeli healthcare system, Isaac would die if not led carefully through each step of the treatment. After several months, the young man completed his chemo rounds and eventually went into remission.

Sandra spoke of many patients with the same quasi-parental affection. When another of her patients received a deportation order while undergoing chemotherapy, she gave him a card to carry with him that explained his immunosuppressed condition in Hebrew and listed her phone number, in case he was detained by immigration police. She hoped, she said, that police officers would be overcome with compassion and send him to hospital instead of a detention center.

Despite formal prohibitions, Sandra was gradually able to obtain chemotherapy for the majority of her asylum seeker patients. It was a success she credited both to her colleagues’ sympathy and to the system’s porousness. “Profit or loss is not the hospital administrator’s

problem,” she explained. “So maybe the administrator would be pissed, but even he cares to a degree only.” She then clarified: most of the doctors and bureaucrats she knew, she said, shared a “delight in lying” in order to sneak patients into hospitals. “Everybody teaches me new tricks, and even the hospital administrators hate the system in Israel. My colleague can teach workshops on bypassing bureaucracies. The hospital admissions receptionists who earn minimum wage don’t really care about their hospital’s budgetary deficits.”

Sandra’s comments disaggregated the medical system into its individual actors. Instead of an impassive and impregnable entity, the system emerged in her description as a loosely governed institution whose members were frequently able to circumvent its bureaucratic restrictions. Sandra’s optimism left out a lot of her team’s weekly failures to secure such *combinot*; indeed, Louisa, AHE’s clinic caseworker, disagreed with Sandra’s upbeat account. In Louisa’s experience, she said, oversight was stronger than Sandra had implied. Hospital insiders, Louisa argued, were a rarer asset than Sandra had implied, and they often hesitated to lie about patients’ conditions more than once or twice for fear of risking unwanted scrutiny from hospital administrators.

Louisa coordinated care for many of Sandra’s patients. A soft-spoken woman with a master’s degree in postcolonial studies and a weary demeanor hardened into cynicism by years of human rights work, she possessed a long memory of failures to sneak patients into treatment. Whenever a hospital insider was needed to circumvent policy, Louisa explained, she would draw up a list of candidates and send them subtly worded emails requesting their help. In case these emails were read by others, she rarely mentioned any subversion of policy in explicit terms. Practitioners, rather, intuited what she really meant and responded in an equally laconic fashion to indicate yes or no.

Much to Louisa's chagrin, an emergency room physician had recently said no to an oncological patient needing surgery. She had known him for years as a reliable AHE contact. Typically, she said, the man responded, "No worries, just bring [them] in." This time, however, he wrote he was sorry but it (the still-unnamed favor) would be too risky. "Maybe you can find someone else from the inside to help out," he had written. Something must have happened at work, Louisa speculated as she read the email aloud at her desk, taking a deep breath to suppress her frustration. After a pause, she added, "Sometimes I feel less like an aid worker and more like a petty bureaucrat at the Ministry of Health, sitting here in this office and telling patients no."

Louisa was in charge of a team of volunteers that worked to negotiate surgery, rehabilitation, and chemotherapy for patients. A lengthy word processing document on Louisa's office computer was titled "complex patients," containing summaries of life-threatening or chronic conditions that did not qualify for emergency room treatment. These patients, Louisa explained, were gradually making their way through AHE's rudimentary tracking system: volunteers would call up contacts and institutions in an effort to negotiate discounts, allowances or donations for a patient. Then, they would log in to the "complex patients" document and add a note describing what they had accomplished during their shift. Each entry was signed and dated, creating a basis for institutional memory that helped offset the high turnover of volunteers.

Some entries were brief, but others spanned several pages, detailing the mundane roadblocks and uncertainties that emerged along the way:

Distal tibial chronic osteomyelitis: He needs surgery and long-term rehabilitation, estimated to last several months. Was assessed at the orthopedic clinic at hospital X. The head nurse and other doctors are trying to find a solution for him, but without much success. We involved doctors Y. and Z., not much success. Trying to get an orthopedic specialist on board. September 20: [volunteer A] has spoken with Dr. R. from orthopedics in hospital X, says it's a minor surgery that will require only 4 days' hospitalization. We're in touch with M. from medical tourism department who'll quote us a price: 050-111-1234. [Volunteer B] will speak with Dr. S. who will write a letter

explaining this short procedure precisely. Once there's a letter we'll try sending him to volunteer orthopedic specialists to see if anyone can help and to Dr. W. Dr. S.'s phone number: 052-111-3456. September 29, [volunteer C.]: sent an email to Dr. T. and Dr. A. and Dr. E. who expressed interest in helping. October 26: Still waiting for a quote from hospital [Y]. Hospital X quoted a price for the surgery of 30,000 NIS. November 18, [volunteer D.]: the patient has 3,000 NIS for the surgery. We submitted a request to [foundation X], perhaps they'll agree to transfer money to him that they had earmarked for another patient. [Volunteer E] is in touch with them. January 17, [volunteer D.] [foundation X] cannot fund it. Dr. P. approved another grant at a high priority, he can take the rest (maybe 10,000 NIS). He has an appointment next week with Dr. F regarding rehabilitation and then we can start. [Volunteer B.] will write a letter to hospital C...

This entry, only a portion of which is reproduced here, illustrates well the banal roadblocks habitually characterized these negotiations. Most delays were incurred while waiting for hospitals to issue price quotes or for practitioners to call back. Some hospitals gave discounts, while others did not. And different hospitals quoted different prices for the same procedures, behooving volunteers to find those that were cheapest – for example, East Jerusalem hospitals tended to be cheaper than ones in the Tel Aviv area. It was then up to Louisa and her team of volunteers to piece these resources together. Meanwhile, more fortunate patients were able to put together enough money to pay for at least some of the procedure.

As Louisa put it, if enough of the puzzle was completed in a timely fashion, or in other words, if donations, partial self-pay, and willing practitioners all fell in line at the same time – then treatment was usually feasible. But most of the time, some parts of the puzzle appeared while others did not, leaving patients in limbo for months, uncertain of whether they would ever be treated. As Louisa explained,

If we arrive at a particular diagnosis and the treatment is very expensive, *and* the patient has no money, *and* we don't have the necessary contacts in this particular case, then we have no ability to do the *combina*, okay? In such a case, this person will remain under some kind of follow-up with us, at least to monitor and see if their situation deteriorates or not. But the reality is that often, chronic conditions do deteriorate, get to the emergency stage, and then they already get treatment at the hospitals through the emergency room.

The difficulty was, Louisa continued, that by the time many patients deteriorated enough to qualify for emergency care, their underlying conditions were much more difficult to treat. In the case of life-threatening conditions, for example, they might receive only ineffective or palliative care in hospital.

Waiting for this deterioration, therefore, was a mixed blessing. Yet despite being significantly more pessimistic than Sandra about the success rates of *combinot* at AHE, Louisa confirmed that oncological cases were a positive exception to the typical downward trajectory. “Sandra has unbelievable powers of persuasion with her colleagues,” Louisa said one night while giving me a ride to the bus station after a shift. “I make one call to Sandra and I know the patient is set.” Over the course of a year or two, dozens of oncology patients received life-saving treatment in Sandra’s hospital in a manner that, to very little fanfare, transformed from rare acts of kindness into a fairly regular assembly line of care.

While recognizing the importance of this shift, Sandra spoke of it with nonchalance and waved away any compliments. She was already focusing on other hurdles, such as the limits of her network’s reach outside Tel Aviv. If possible, it was often more convenient, she noted, to circumvent the hospital system altogether using donated chemotherapy pills and injections that could be administered outside hospital settings. Over time, she chuckled, she had developed a word-of-mouth reputation as a “hoarder of pills for refugees,” and oncologists all over the country began sending her surplus medications. Some treatments were even mixed in volunteers’ kitchens, she admitted in a hushed voice, indicating that formally, this was very much counter-indicated.

“Would it work in other places?” Sandra asked, repeating my question about her successful *combinot*. “It’s very Israeli. I could never do this anywhere else, it’s all connections:

a friend brings a friend, calls the ER, says ‘I had coffee with you in the army, so help me...’ Everybody understands this here.... It’s the *combina* method.” Her young protégé, a medical resident named Jaron, she added, believed so strongly in the “Israeliness” of the *combina* that he hesitated to move to the U.S. with his American girlfriend, worrying that he would never be able to pull off the same kinds of *combinot* for marginalized patients in the U.S.

But Tom, AHE’s executive director, politely disagreed. Backrooms deals of this sort, he noted calmly, existed in every bureaucracy. “Germany,” he admitted, “is perhaps more bureaucratic, so maybe here in Israel it is easier to sneak people in from the side, either to go behind official channels, or to bend the official channels themselves. But in every medical system there are margins. What they look like and how wide they are will vary.”

Sandra credited AHE’s intricate system of *combinot* to Israel’s relatively small medical community, where it was not uncommon for an oncologist to know every other oncologist in the country. Other AHE staff, meanwhile, more cynically attributed AHE’s successes to the lack of transparency of Israel’s state bureaucracies in general. In Holland or Germany, Louisa speculated, she would never be able to sneak so many patients into a public hospital’s emergency room. AHE’s *combinot* worked to the degree that they did, she argued, because they were dominant modes of operating in all walks of life in Israel, including its public healthcare system.

Other sources corroborated her intuition regarding the ubiquity of *combinot*. In June 2013, *The Marker*, a center-left economic newspaper in Israel, ran a critical story about the insidious privatization of healthcare in Israel (Linder-Ganz, 2013). Each year, the article reported, specialist slots and procedures were migrating from the public to the private system: practitioners were working fewer hours in the public system and more in the better-paying private system, and some public hospitals’ equipment was increasingly made available only to

patients paying much higher private fees for faster service. Family physicians interviewed for the article protested the erosion of the welfare state. Some even conceded that in order to protect their patients from the fallout of privatization, they had to bypass the system's queues and "activate personal contacts," or to "refer their patients to emergency rooms" in ways they intimated were "inappropriate." The actions they hinted at, in other words, were part of AHE's daily repertoire, but since these differentially privileged some Israeli citizens over others, rather than helping non-citizens who had no recourse to a "normal" queue, they raised a different set of concerns about social justice, corruption, and the misuse of public resources.

Dampening this show of surprise and indignation, however, a few AHE aid workers shrugged and said that there was nothing surprising about a practitioner calling up an old colleague and asking them to see a patient in desperate circumstances. However objectionable such behavior might seem from a fairness standpoint, such *combinot*, they insisted, had long been common practice throughout the healthcare system. AHE's workings, they implied, differed from the governmental healthcare system less in kind than in degree, a similarity that helped make AHE's strategies successful.¹⁶

COST-CONTAINMENT LOGICS OF CARE

When AHE sent patients to hospital emergency rooms, they were typically treated immediately and billed later on. Many of these bills went entirely or mostly unpaid. Hospitals absorbed these costs and negotiated their debt grievances with the Ministry of Health, often with

¹⁶ Some AHE volunteers, noting the continuity between their AHE work and similar *combinot* in other spheres of life, were reluctant to refer to their AHE work as "humanitarian," preferring to simply talk of "volunteering." Much of the work done through AHE, then, compared with aid workers traveling to post-earthquake Haiti, for example, was seen by its providers as what anthropologist Erica Bornstein has called "unofficial and ad hoc humanitarian work," or aid that was "off the radar of more formal humanitarian organizations" (2012, p. 19). In Bornstein's ethnography of humanitarianism in New Delhi, the acts which she cumulatively referred to as "humanitarian" consisted of a mix of formal NGO work, donations by Indians residing in the diaspora, and the work of Indians returning home to volunteer. See Brkovic (2014) for a similar discussion of informal, one-off acts of humanitarian assistance in Bosnia.

limited success.¹⁷ Some hospital bureaucrats, then, developed a dislike for patients they knew would not be paying for their treatment. AHE's patients, often immediately identifiable by the color of their skin, presented easy targets for such frustrations, and were sometimes warned to pay in advance or leave. On several occasions during my fieldwork, AHE volunteers had to call hospital receptionists to remind them of the Patient's Rights Act's mandate of unconditional emergency treatment, or even go over in person and demand that patients be admitted.

Hospitals had other ways of minimizing costs. Asylum seekers still owing money to a hospital after emergency treatment, for example, were often banned from follow-up care at that location. This resulted, Uri said, in some absurd and comical situations. For example, a patient treated at a hospital emergency room for a broken arm or a dog bite would not be permitted to return to that hospital to have her cast or stitches removed, since these no longer counted as emergency conditions.

In a standard hospital practice, moreover, discharged patients were typically referred for follow-up care at the nearest governmental community clinic. Asylum seekers' own discharge letters typically contained similar language, but governmental clinics were off-limits to them. ER practitioners who realized this sometimes scratched out "community clinic" and wrote "go to AHE!" by hand just above the typed instructions, their hastily hand-written note reflecting either a last-minute recollection or an effort to avoid complications by leaving mentions of AHE out of the hospital's official electronic record.

AHE staff often reacted to such scribbles with a mix of mirth and frustration. "At least they directed the patient to the right place," Uri once chuckled, holding up such a letter for his colleagues to see. The "right place" was Uri's cynical joke; as he and his colleagues knew well,

¹⁷ Two AHE staff members claimed that the Ministry rarely reimbursed hospitals more than a third of the cost of treatment for asylum seekers, a figure I was not able to independently corroborate.

patients were often discharged with post-operative complications that required complex ongoing care, and which AHE lacked the infrastructure to provide. Uri thus marveled at the irony of a well-equipped government hospital referring seriously ill patients to a scrappy NGO for follow-up. Unable to direct the pressure upwards to their own hospital's administration, doctors who signed these patients' discharged letters became unwilling pawns of the Ministry of Health, expressing in the most matter-of-fact way possible the fact that their country's obligation to poor non-citizens had ended; their conditions were no longer deemed an immediate emergency.

Government hospitals, then, presented an ongoing struggle for AHE. Its struggle was not with medical practitioners, but with bureaucrats who saw asylum seekers as economic liabilities and a drain on their budgets. However, there was also a curious exception to this pattern. During my time at AHE, several lines of credit suddenly opened up in different public hospitals that enabled asylum seekers to receive certain tests and treatments for free. No one was sneaking patients into emergency rooms here; these free treatments typically occurred with the full knowledge and cooperation of certain high-ranking administrators who might otherwise be expected to refuse such accommodations. Initially, I was perplexed to see such arrangements become possible in a period suffused with more public antipathy than sympathy toward asylum seekers.

In Sandra's telling, these were classic *combinot*, made possible through a combination of persuasion and compassion. She recalled one of her own experiences:

A year ago, there was a case with a Ghanaian woman with a severe asthma attack. She had a tracheostomy and became mute. I asked the hospital head to approve surgery for her at 20,000 shekels. He had approved other requests, but refused her. Two weeks later, she died. I freaked out. She could have been saved. I wrote a letter to the hospital manager and told him politely that I thought he was responsible [for her death], that she had died because of 20,000 shekels, which is nothing. And really, it's not 20,000. When hospitals price things, they include the electricity in the toilets; in practical terms it doesn't cost that much. The hospital manager turned out to be a good man, after all, and

he said, “[Sandra,] come on, let’s meet.” And I told him we needed a fund, [that this hospital should] take some of the burden, and so it rolled... We had more meetings with the finance people... we got lucky too because the manager was a small manager, and the big manager wasn’t involved with it and he hates me anyway. The smaller manager was on board and the finance manager was the mother of someone who went to school with me.

Sandra’s account downplayed the difficulties of obtaining such arrangements, invoking the narrative of rogue practitioners determinedly skimming resources from a bloated state system for the sake of patients who are systematically excluded from it. The fund she had obtained, Sandra emphasized, was not official policy. Instead, it was more of a public secret (Taussig, 1999), which perhaps only a handful of bureaucrats and doctors knew about:

It’s not official, since a governmental hospital can’t say it’s donating public funds. It’s not the hospital’s money. So honestly, it’s the good will of a lot of people willing to broaden the boundaries of what’s allowed. But it’ll never be in the newspaper. So I always tell AHE staff “don’t publicize it, it needs to be quiet.” But inside the hospital I’m no longer quiet. I already have a fund I know I can use, and that it’s procedurally okay. All these little lies - I don’t have to do those anymore.

Despite Sandra’s emphasis on “the good will of a lot of people,” there was more than altruism at play in the periodic generosity of government hospitals. Tom, AHE’s executive director, pointed out that the Ministry of Health had a vested interest in giving some free preventative care to asylum seekers – primarily blood work and imaging tests – in order to save money on more expensive emergency room care later on. This generosity, in other words, reflected not only compassion, but also a straight-forward cost-containment logic (Filc & Davidovitch, 2005). Indeed, in their public campaigns for healthcare reform, AHE staff sought to capitalize on this logic by arguing that including asylum seekers in a comprehensive governmental healthcare plan would save the Israeli government money in the long run. Some media reports on the refugee crisis echoed these same arguments (Even & Neshet, 2013).

As Tom further pointed out, there were other advantages to government hospitals' selective generosity. By getting involved in the care of asylum seekers, albeit in a very limited way, hospitals were able to gather intelligence regarding common illnesses in these populations. These types of epidemiological surveillance were far from comprehensive or systematic, Tom acknowledged. Nevertheless, like the free tuberculosis and malaria tests, they served an important public health agenda.

By and large, AHE and government hospitals shared an interest in keeping their "line-crossing" arrangements quiet. The latter wished to be spared the ire of government officials and right-wing politicians anxious to avoid attracting new asylum seekers to Israel with the impression of government handouts to asylum seekers. AHE, meanwhile, likewise sought to maintain its public image as valiant fighter for sweeping healthcare policy reforms, rather than the broker of temporary and partial solutions.

At the same time, not all of these arrangements were hidden from the public eye. Free tuberculosis tests, for example, were easy to justify publicly as protecting the Israeli public from infectious disease outbreaks. In January 2013, the Ministry of Health justified a modest uptick in governmental care for asylum seekers by noting that "the absence of medical support for refugees could impact the local population and the Israeli public at large" (Even & Neshet, 2013). In other, albeit rarer, instances, governmental hospitals disclosed free surgeries for migrants on their donor brochures and newsletters, a transparent public relations move that nevertheless took by surprise AHE staff who were accustomed to dealing with irate, nay-saying bureaucrats.

Overall, these discounts and lines of credit blurred the boundaries between governmental and non-governmental medicine, entitlement-based and compassion-driven care, and official and

unofficial channels of treatment, suggesting that the forms of improvisation that take place under governmental and humanitarian auspices may differ less in kind than in degree (and in certain porous governmental bureaucracies, perhaps not even in degree). This was not simply a story, in other words, of aid workers necessarily subverting governmental resources. Rather, as Sandra's meetings with hospital bureaucrats indicated, the system itself was sufficiently flexible and suffused with patrimonial understandings to permit the siphoning of funds into an asylum seeker budget in contravention of official Ministry of Health prohibitions. Indeed, the presence of multiple agendas beneath a seemingly monolithic policy of exclusion – cost-containment, charity, epidemiological surveillance, and humanitarian posturing – illustrated well Rosalind Eyben's notion of policy as being “relational, contested, and never-finished process” (2011, p. 20).

Writing of aid work in a Bosnian town, Carna Brkovic (2014) similarly illustrates the “overlaps between personal and institutional knowledge” that emerged when town residents drew upon clientelist networks and porous spots in welfare bureaucracies to provide aid to families in need (p. 12). “Municipal governments,” she writes, “occasionally acted like charitable organizations which made a selection between worthy and unworthy recipients and occasionally they acted like a bureaucratic system blind to the social positions of its members” (p. 14). A similar multiplicity, I argue, was present in Israeli governmental hospitals, and AHE staff were able to take advantage of it in order to negotiate certain treatments.

The AHE staff I spoke to said they did not know how hospital's lines of credit for asylum seekers were justified internally, or who ultimately paid for these treatments. As Sandra put it, “It's an agreement where I bring people in and the hospital approves. How much? I don't know. What's the limit? I don't know, it's not official. If I stretch the line too much it'll rip.”

Meanwhile, Tom, AHE's executive director, was happy to describe various lines of credit to me, but asked me not to speak with hospital administrators out of concern that too many questions might cause these funds to disappear. He had reasons for doing so. While Sandra's fund did last throughout my time at AHE, others periodically dried up, forcing AHE volunteers to find alternative solutions or report the bad news to their patients. The impression of stability that these funds provided – by virtue of being more than simply one-off acts of kindness – only intensified patients' and aid workers' disappointment when they ran out.

FAILURES

One afternoon, I asked Louisa how much money patients typically had to contribute to their own treatments. Uncharacteristically, she lost her temper, berating me for seeking regularities where she said there were none. "Every case is different, it really depends," she added some moments later. "Some people don't pay anything, others pay a bit... in short, *combinot*. We have no official way to arrange this." She reminded me that at AHE, any treatment beyond the most basic primary care was subject to the fickle mercy of volunteers and bureaucrats. A few forms of treatment were "basic" or "standard," she conceded, and could be counted on to be present at AHE when uninsured patients needed them. "A clinic can help with the flu," she gave an example. "To give antibiotics, check one's temperature, blood pressure, diabetes, things like that. But in [complex] cases we depend on our contacts, and on the flexibility, such as it may be, of public medical institutions." And this flexibility, she emphasized repeatedly, was generally not to be trusted.

Due to their day jobs in government hospitals and clinics, many AHE volunteers were keenly mindful of the temporal and structural differences between governmental and humanitarian medicine. They spoke often of these differences, often lamenting AHE's lack of an

organized infrastructure in comparison with the state's medical bureaucracy. As Ilana, the clinic's former manager, put it, "in the [governmental] health system, there's a *system*. There's bureaucracy, there's people to turn to. It's flawed but protocols exist. Here there's nothing, there's you and you have all this crazy responsibility." Volunteers lamented AHE's unpredictability compared with the relative stability of healthcare protocols and practices in the governmental system. "Because of the high turnover [at AHE], few doctors have the whole picture about a patient," Uri told me. "Doctors don't have time to read a patient's entire medical file, or it's out of order, with papers from 2007 next to ones from 2011. Or referrals are given for no reason, or with no explanation why." He regularly helped Adí decode illegible or impractical referrals. But before he could do so, some order was needed: "I arrange files by chronological order. I photocopy them. We document the medical history and trace it through all the mess."

It was rarely enough, however. Because most of AHE's medical volunteers often came "only 1-2 times per month," said Meirav, an internal medicine physician and AHE board member, "it's hard to form a team culture, to put together work protocols." It was difficult, she explained, to teach them to write down referrals in such a way that anybody would be able to understand them. As Adí wryly put it, good referrals at AHE's clinic had to be written in "diplomatic language," not "medical" language. In a clinic or hospital, "medical" language was the norm, and as AHE volunteers put it, it was an efficient way to carry on. But at AHE, experienced volunteers knew it was important not to use overly technical or obscure medical jargon in their referrals, since one rarely knew whether the next person to look at the file would be a specialist, a general practitioner, a nurse, or a medical untrained volunteer attempting to decipher a referral in order to pass it on to another volunteer.

Most volunteers spent so little time at the clinic that they struggled to write referrals in this manner, preferring the technical shorthands they had long been accustomed to and which subsequent volunteers sometimes struggled to understand. As Meirav put it, “everybody has their own ideas, suggestions. They all do things differently. There is no standardization of labor.”

Rebecca, the clinic manager, was aware of these difficulties. In one report to a donor, she acknowledged them with surprising candor in the “Ongoing Challenges” section:

The large number of volunteers of all kinds, as well as the high turnover, makes it hard to establish clear procedures for the clinic's work, and for organizational knowledge to be accumulated rather than lost. This is especially challenging when it comes to the team of nurses and medical students who are in charge of the medical triage: they hold a key role in the clinic, yet their experience and training vary and it's hard to create a unified protocol which would be followed by all. This creates various problems such as an overload of unnecessary referrals, inconsistency in the managing of files, etc.

Many of Louisa's colleagues accepted AHE's inability to treat every patient as an unavoidable reality. This was the most that a humanitarian clinic without stable resources could accomplish, they often said. But Louisa adopted a more cynical approach, noting that AHE had more opportunities to save patients than it capitalized on. As patient numbers rose following the influx of asylum seekers through the Sinai border, for example, AHE's members debated recruiting additional volunteers, opening clinics in other cities, and doing more intensive fundraising for treatments. But the organization's desire to keep the pressure on the Israeli government high typically undermined such initiatives. In Louisa's estimation,

There are failures in the way we work. It's all a result of enormous workloads and a very fragile infrastructure. Sometimes we work more like an ER than a community clinic. It's hard for patients to find quality care with us. But to a certain degree, as you've probably understood already, it's more or less on purpose. The clinic was not expanded, our services were not expanded, so that the clinic would remain in a state of perpetual distress. So that it would not be a good solution.

The result, Louisa argued, was a profoundly unstable healthcare system whose capacity for treating its own patients was always unknown. Who would take care of these patients, she asked, if Sandra or her colleagues suddenly stopped volunteering or moved abroad to work for higher pay? Her colleagues liked to bask in their own successes and heroism, Louisa noted sarcastically, but moving abroad or ceasing to volunteer for other reasons were both plausible scenarios, illustrating the ethical difficulties of leaving a population largely in the care of a handful of volunteers without long-term commitments. “If this same volunteer stops volunteering with us,” Louisa said, referring subtly to Sandra, “then we don’t have any recourse anymore for oncological patients. It’s not something that is institutionalized.”

Sandra, for her part, appeared to agree. In a conversation several months later, she speculated that deterioration to emergency must have happened to many patients before she came to AHE. “Most of them would die silently,” she responded to my question of what AHE patients had done or would do without her. “No one knows they’re ill and they die silently. Or they end up at the ER after metastasis has occurred and get only palliative care.”

The nightmarish prospect of key volunteers, who ran most of the operation single-handedly, ceasing to volunteer with AHE was already effectively present, Louisa argued. “We function as a community clinic, but we don’t have the ability to give quality follow-up,” she said, referring to AHE’s high volunteer turnover. During our conversations, Louisa consistently fell in line with AHE’s standard advocacy pitch, maintaining that the Israeli government should assume the lion’s share of responsibility for asylum seekers’ healthcare, and that the blame for AHE’s failings rested ultimately with the government. Still, she found it difficult to knowingly forsake patients in order to promote an advocacy goal.

AHE's mandate required a delicate balancing of aid and advocacy. "We can't let a man die while he's waiting for an answer from the Ministry of Health," Louisa said. "We'll get him a *combina* and at the same time go to the Ministry" to demand policy reform. But as patient numbers increased without a corresponding increase in organizational capacity, the metaphor of a single man about to die became an increasingly ill-fitting representation of the situation at hand. The real situation, as many aid workers experienced it, was a mix of uncertain needs and unpredictable patient volumes. AHE had not a single man dying on its doorstep, but rather, "an indistinct crowd" clamoring for aid (Redfield, 2014, p. 228).

Some AHE staff members bristled at the suggestion that AHE's failures might be deliberate. They were not, most staff members often insisted; rather, they were a complex byproduct of too many patients coupled with the need to keep humanitarian aid limited in order to avoid becoming a permanent second-rate solution for asylum seekers, which was precisely what the Israeli government wanted.

I asked Ronen, a mild-mannered home care nurse in his sixties who had been volunteering with AHE for nearly a decade, where he thought the proper balance lay between too much and too little aid. He deftly avoided the question, noting that such "political questions" were precisely why he chose to stay away from AHE's political arguments and focused only on its "humanitarian side." AHE's brand of humanitarianism, he said, was bad for patients' health in the long run. "Sometimes a diabetic will get a blood test [here], [and] sometimes not," he noted. "Sometime there's insulin, sometimes there isn't." He was critical of this indeterminacy, and perceived it as a function of conscious decisions made to limit care, rather than a simple lack of resources. Even when the focus at hand was primarily on aid, he explained, the possibility of limiting aid in favor of politics always lurked in the background. "I try not to get involved in the

political dimension,” he explained, “because in my opinion, once you add politicization to treatment, it’s not healthy. I come from a place where I think that help should be given as help, not as politics.”

The AHE clinic often seemed chaotic to observers and new members: volunteers came and went, files were misplaced, and appointments went unfilled. Adí could barely contain her anger upon discovering such neglected cases. “His MRI showed a rare malignancy and he’s been on our books for a year and no one knows about this!” She shouted one morning, waving a patient’s file at a startled colleague. “Who knows where this patient is now, or if he’s still alive.” To an observer, it did indeed seem astonishing that no one had caught this file earlier, given how earnestly volunteers toiled to save lives. A measure of arbitrariness seemed to accompany life-saving at AHE: some patients, like Isaac, were accompanied to each chemotherapy appointment and helped with food and shelter. Other patients were less fortunate.

When I told Louisa about the neglected MRI case, she was pained but not surprised. I was eager to find out why, despite the intricate patient tracking system she had constructed for complex patients, some patients with severe conditions were still occasionally forgotten. On one volunteer shift, for example, I had been instructed to call a patient regarding an orthopedic surgical procedure. In response, he asked in anger why it had taken AHE six months to call him back. Startled, I echoed his question to Louisa, asking when and why such appointments might take so long to schedule. “It could be many stupid reasons,” she responded, elaborating:

The appointment isn’t supposed to take six months. Could take two months, easily. It could be simply because someone forgot to open a referral in the file, and then the patient won’t show up [in AHE’s electronic tracking system] as waiting for an appointment. Or there was an appointment and they called him and couldn’t reach him because he changed phone numbers and didn’t inform us. Or just because we did not have enough manpower to go over all the orthopedic patients in six months. There might be fifty of them.

I was surprised at Louisa's matter-of-fact attitude to such failures. Even more peculiar, however, was the complacent reaction of Adí's more senior colleagues to the neglected MRI patient. Most of them shook their heads in sympathy and made oblique references to the Israeli government's ultimate responsibility in the matter. But no one seemed to take charge or call for tighter volunteer protocols or higher staffing, which might prevent such neglect from re-occurring. Indeed, while Adí's "sitting on files" was universally praised as invaluable in saving patients, this responsibility remained largely hers. Throughout my time at AHE, her scrutiny of complex files was never delegated to others or codified into protocol. When I asked who had done this before her, or who would take over once she could no longer do it, no one seemed to have a clear response. Tom, AHE's executive director, noted blandly that another volunteer might take over.

By way of softening the blow of habitual neglect and failure, aid workers at AHE enjoyed telling stories to one another that affirmed their own care-giving while placing AHE within an imagined hierarchy or spectrum of care. Sometimes, these stories pertained to other humanitarian settings that seemed worse off than the clinic, helping to cast it in a positive light. One night after a shift, Li'or shared such a story: a few years earlier, he had gone to volunteer at a medical NGO in rural Ethiopia. "People there had nothing," he said. "They'd walk to the clinic along mud paths for days, with their babies strapped to their backs." Waiting for the imagery to sink in with his audience, he then went on to say that the clinic was so woefully underequipped that they hardly managed to save anybody's life.

One day, a man with a melon-sized tumor protruding from his abdomen arrived on foot after a long trek. "He expected us to work miracles," Li'or recalled. The man collapsed to the dirt floor and waited there quietly all evening. Aid workers realized there was nothing they

could do for him. He stayed there until nighttime, when several local men lifted him up and put him outside in the dirt, so the clinic could close. When Li'or arrived the next morning, he was gone.

To Li'or, most astonishing was the seemingly unmoved, matter-of-fact way in which the men had carried the patient out of the clinic. Instead of protesting and scrambling madly to save the man's life, everyone in the room had looked on with what seemed like equanimity. This struck Li'or as tantamount to a shocking acceptance of death – the sort of thing that any self-respecting humanitarian worker would refuse to countenance (Redfield, 2013). As Li'or reflected back on his own complacent reaction to the man's removal from the clinic, his listeners experienced competing feelings. Although the story was sad, it contained some elements of relief, vindicating AHE's own flawed aid work as more successful by comparison. At the same time, the story served as a painful reminder that all humanitarian endeavors, theirs included, constituted but minor and inadequate responses to inequality.

The challenges of treating patients at AHE, then, exceeded understaffing and ambiguous humanitarian mandates. Namely, aid work also required a different way of practicing medicine than most volunteers were used to in their day jobs. Meirav referred to it as *migrant medicine*, indicating a form of practice that required doctors to stop assuming they could rely on sophisticated diagnostic tests, or that they would see a patient more than once. In the next section, I illustrate how AHE staff attempted to learn and practice such medicine at the clinic.

MIGRANT MEDICINE

“Suppose I order tests for a patient,” said Li'or, a rail-thin, curly-haired medical resident in his late twenties who smoked often. We had walked over to a café near the clinic at the end of a relatively easy shift. Li'or spent several hours a month at the clinic, juggling aid work

alongside his medical residency and two part-time jobs. At a governmental institution, Li'or said, "the test results would automatically be sent to the family doctor, and the doctor would then call the patient." Meanwhile, at AHE, "patients get tests done in the different hospitals that donate them, and if patients don't come to us with their results, we can't call them," he said, whether because their phone numbers were out of date or because it was too difficult for Louisa or Rebecca to keep track of the tests and institutions. For reasons as banal as these, Li'or continued, many patients fell through the cracks, and illnesses were left to develop untreated.

"It's problematic to trust patients to take care of themselves," he added. "Even Israelis; but especially refugees, who are very busy and very poor." Problems with patient follow-up were a regular topic of discussion at AHE staff meetings, but in practice, Li'or said, follow-up seemed to him to be "completely voluntary. I once took a patient's number and called him two weeks later to make sure he'd come back to us... but there's no protocol for it."

Volunteers had to learn to work around sparse equipment, and to "work short and fast," as Meirav put it. Newcomers' careful patient intake interviews (anamneses) often took 15 minutes or more, creating long queues in the AHE waiting room; these would not do. Working "short and fast," Meirav said, was crucial in a clinic such as this one. It was likewise critical for a practitioner to not assume that she would see the same patient twice. "You sometimes can't trust people to come back to *you*," she said. "They'll see another doctor. There's a thing called migrant medicine which isn't really practiced [in government institutions]: the assumption that this may be your only encounter with people and you have to give them a solution *now*."

Dori, a medical resident juggling evenings at the clinic with his residency, explained why this principle was difficult to internalize. "Medical training forces you to memorize and go by rote through protocols, that anybody with X symptoms should get Y tests," he said. "It's been

hammered into you for so long. It contradicts your training to start messing around with cheaper tests.” At AHE, he argued, “you have to learn a kind of medicine that doesn’t really exist in hospitals anymore.” In government hospitals, he explained, a single practitioner rarely had sole responsibility for a patient. At AHE, in contrast, practitioners often felt as though they did have such responsibility, a sensation that medical residents initially found exhilarating. But soon, the sparse equipment frustrated these young practitioners, who were not yet accustomed to improvising or making life-or-death decisions. “Every day you’re taught that it’s irresponsible not to give a patient a CT scan, and suddenly here you realize, okay, there’s no CT.”

Ilana, a former clinic manager, noted that even veteran practitioners occasionally found AHE too foreign or uncomfortable to practice in, and quit quickly. During her tenure as manager, she recalled, a senior gynecologist had once arrived for his first AHE shift. “He said, ‘where’s the [ultrasound] gel?’ I told him, ‘we have none, we use Vaseline.’ And he packed his bag and left. I was left standing there with a room full of women, and I didn’t know what to tell them. I wanted the ground to swallow me.”

Adí, the internal medicine specialist who revised referrals, was eager to give crash courses in migrant medicine to anyone who asked, as well as to those who did not. Her first lesson, she announced, would be: staff should not give treatment or referrals for problems patients could fix on their own. “He’s a 19 year-old who can’t see well?” she said one morning while sitting on files with Uri. “Don’t use up an eye doctor appointment! Have him go to the pharmacy and try on different prescription glasses until one works. Fixed!” She grinned impishly. Uri agreed: “Getting here from Eritrea without a plane takes considerable resourcefulness (*tushi’a*), yet suddenly they can’t go to the pharmacy to get glasses?”

Medicine at AHE, Adí argued, required volunteers to take extra time to ask patients about their daily routines. This was good practice for any doctor, she acknowledged, but was particularly vital in this clinic, where scarce resources ruled out a reliance on advanced testing. Most practitioners, she lamented, did not internalize this need; but once in a while, she came across as an “excellent” intake report, she said. By example, she tossed one over to me so I could read it. Agnes, one of the triage nurses, had received a patient with a complex eye infection a few days earlier. Unlike many of her colleagues, she did not recommend a specialist; instead, she asked the patient about his occupation. “See?” Adí said proudly, her fingers tracing Agnes’ hand writing. “She’s asking the right questions. The man comes in with an eye infection, and she asks him what he does for a living. She writes that he works in construction but doesn’t wear protective eyeglasses at work. Good for her.”

That Agnes had been thinking occupationally, rather than rushing to refer the man to another practitioner, impressed Adí. “There’s improvisation in every medical institution,” she said. “But here we need more improvisation. It’s also more of a return to minimalist medicine,” she added, “where we actually touch a patient’s knee instead of sending them immediately for an imaging test. No over-testing or over-medicating here, if only because we simply can’t afford it.”

Working at AHE, Meirav concurred, often called for immediate, low-tech problem solving, whether because follow-up care was inaccessible, expensive or logistically complex to carry out. Immediate solutions, she continued, often involved blood tests or medication for patients to take home with them, even if they weren’t strictly necessary. “Medicine is a *property* that they now have, and which they didn’t have before,” she gestured at the dozens of patients in the waiting room. “They got something for their long wait. For example,” she continued, “a lot

of African migrants appreciate and want blood tests. There's a special significance to blood-letting, releasing from spells and diseases. They ask for blood tests as something almost therapeutic, even when not related to what they're actually suffering from."

Meirav did not know why "African migrants" valued blood, but was certain they did. When I asked her to elaborate, she blandly advised me to look for anthropological literature on Africa, assuring me that abundant answers would be found there. Ronen, the home care nurse, reported similar experiences with his own patients:

They need cutting, they need blood... A week ago I had somebody who had very severe back pain. And I gave him a Voltaren injection.... It's for pain, back pain which is associated with an internal edema. The Voltaren releases the edema, releases the mobility, and the pain passes... As luck would have it, I'm good at giving injections, so his didn't hurt. Now, you'd be happy, wouldn't you, if an injection didn't hurt you, right? Not him. He tells me, "Is that it!?" I say, "How come?" So he tells me, "It didn't hurt." I say, "You wanted it to hurt?" He says, "Yes, if it didn't hurt, you didn't give me any stuff [*homer*]!" And I say, "But here's the stuff, here's the injection, here's the stuff!" He says, "But it didn't hurt! You didn't give me anything!" This actually happened one week ago, I'm telling you. You see what I mean? They need pain; if it didn't hurt them, then we didn't do anything... It's a mentality. I see it all the time here.

Ronen wondered why asylum seekers appeared to equate painful bodily experiences with proof of healing. Those who struggled with chronic conditions, he pointed out, were also likely to complain that the pills they had been given were not real medicine. They often asked for surgery, he mused; perhaps they were conflating cutting into the body, or higher pain, with higher efficacy.

Other practitioners, meanwhile, gave more pills to asylum seekers than they did to their Israeli patients. Guy, a volunteer psychiatrist, said that asylum seekers did not usually seek him out; rather, they were typically referred to him when their somatic complaints about burning in the stomach turned up no apparent underlying physiological problem. There was no shortage of

emotional issues to address, he noted: many asylum seekers had suffered horrific physical abuse on their way to Israel, or had been torn from their families.

Trying to help these patients posed unique challenges. “You’re left with a lot of uncertainty,” Guy began. “First of all, it’s one-time only. I don’t know if I’ll see them again.” Second, the need for a translator violated some of the most fundamental tenets of the psychotherapeutic dyad. Guy spoke no Arabic, Tigrinya, or Amharic, the three languages most commonly spoken by his patients. As a result, a translator was often present in the room, undermining the fleeting trust Guy was painstakingly trying to build with his patients. “The translator is another person in the room who listens and talks. The client suddenly has to trust *two* people, and tell them both stories.” Guy doubted whether his translators were genuinely translating each side verbatim to the other. Most of them, he said, seemed to be adding their own commentary, or editing what they had heard. “The patient would speak, telling me a whole story, and the translator would give me three words, a summary. I’m interested not in the summary, but in how they talk, in the whole story.”

Gid’on, another AHE psychiatrist, agreed that how patients talked was important, rather than merely the specific information that they conveyed. Sessions with a translator present, he explained, became “a dialogue, not a monologue. That’s a problem. You want to nudge the patient into a monologue, it’s diagnostically vital.” People needed some space and time to think and share their thoughts, Gid’on elaborated, and the translator, whose own priority often seemed to be succinctness, often prevented this from happening. “The back and forth with the translator keeps things short. Of necessity it becomes about everyday things, it’s easier that way.” Yet it prevented more in-depth disclosures from occurring.

Cultural differences in the meanings of symptoms, meanwhile, became important. “Some symptoms sound psychotic,” Guy said cautiously, “but it’s not certain it’s psychotic, it could be cultural. Somebody says he’s being cursed, for example, by demons. It sounds in the DSM¹⁸ like paranoia, but it could also be something cultural.” Having been trained in a school of thought that held that “the application of psychotherapy outside the original European middle-class milieu is limited” (Littlewood, 1992, p. 38; see also Langwick, 2011), Guy was anxious to avoid imposing upon his patients an interpretation that reduced their symptoms to an individual sickness bearing no cultural or spiritual significance.

Ultimately, however, Guy felt his efforts to be a culturally sensitive therapist were made largely moot by language barriers. Medication became the compromise, often in the form of pills for anxiety, sleeplessness, or depression. Handing out medicine with such ease violated his deepest professional instincts, Guy confided, but this setting seemed to require it. “I feel that they should receive something from me. I can’t let them go without anything. And my words, especially when they go through a filter, don’t make much of a difference [to them.] As far as they’re concerned, they’re coming to a doctor and they want a drug.”

Gid’on likewise admitted to prescribing more drugs than was his custom. He also found himself asking more about general sleeping patterns and sensations than subtle feelings. With depression, he explained, you tend to wake up early; with anxiety you tend to struggle to fall asleep. Depressed people, he added, wake up sad and get happier, while with anxiety he found it was often the opposite. These tendencies, he argued, were “pretty much universal,” and simple enough to inquire about using a translator that he felt fairly confident in relying on them with

¹⁸ The Diagnostic and Statistical Manual of Mental Disorders.

asylum seekers. “The way I see it,” he concluded, “it’s not the best diagnosis that I can do, but it would be worse if I did nothing.”

COMPASSION, LTD.

Compassion had important limits among AHE volunteers. Life-threatening illnesses like cancer, for example, tended to elicit more sympathy than chronic but non-life-threatening conditions. This was not universally the case; some volunteers did undertake to monitor heart disease and diabetes patients over time, and to keep their conditions under control. They saw in this work an important mission to prevent their patients’ deterioration and to counteract their colleagues’ prioritization of acute conditions. But on the whole, Louisa explained, many of the specialists in AHE’s country-wide networks tended to associate AHE with acute conditions. Themselves often overworked and underpaid in the Israeli public healthcare system, few were willing to expend considerable personal resources to treat chronic conditions with poor prognoses, or conditions that merely impeded a patient’s quality of life.

One evening in early 2012, an Eritrean asylum seeker in her forties arrived at the clinic with chronic ankle inflammation. Sitting down on a chair in a crowded waiting room, her swollen legs stretched out before her, the woman begged Louisa for money for ankle surgery, explaining that she was unable to work. Squatting down until she was at eye level with the woman, Louisa took her hand and spoke to her in a compassionate but firm tone. There was little chance, she said, that AHE could raise that money or find orthopedic surgeons willing to operate for free. Louisa then asked whether any of the woman’s friends could help with money. At this point, the woman began sobbing quietly, wiping her tears with a tissue as other patients looked on in silence.

This woman had been coming to the clinic for months, Louisa told me later, and it was no surprise. As Louisa put it, “orthopedic cases are the hardest to find funding for.” AHE did not make any categorical distinctions regarding which patients they would and would not try to help, but realistically, Louisa said, “Who’s going to care about this one refugee’s ankles?” Patients like this woman typically got lucky only if an orthopedist somewhere happened to find their particular case medically interesting enough to take on pro bono.

Other chronic conditions posed similar dilemmas. Young male asylum seekers, for example, often complained of chronic back pain. “Of course they have back pain, they’re carrying heavy blocks all day!” Dori the medical resident chuckled, referring to the fact that many of these young men worked in *chik chak* (“fast” or one day only) construction jobs. Israeli citizens with chronic back pain, Dori noted, would be referred to orthopedic specialists, pain specialists, physical therapists, or occupational therapists. But AHE had few such options to offer asylum seekers and migrant workers. “The only supportive medicine we can offer them is to tell them to sleep better, eat better,” Dori said. The clinic, he added, was a “band-aid on a tumor,” more about putting out fires than keeping a population healthy. “You go into a shift and you say ‘there’s so much to do, it’s a ton of patients and I’m not helping at all.’” He explained. “You’re always half playing defense, telling yourself, ‘ok let’s see that it’s nothing severe and then pass the patient on’.”

Such limits on compassion contradicted AHE’s widely repeated view of healthcare as a universal human right, a mantra that was considerably easier to write impassioned advocacy campaigns for than to put into practice. Even though many volunteers openly extolled the importance of unconditional treatment for everyone, their actions often betrayed a concern with

hierarchies of worth, underscoring the fleeting and unpredictable nature of humanitarian medicine. As Avi, one of AHE's founders, noted, in humanitarian medicine,

if you find a volunteer specialist, there'll be someone to treat [these patients]. If not, there won't. It's a kind of philanthropy... but it should be a stable contact, a service that's a right and not a charity. As soon as a clinic is based on volunteers, it's charity. It even affects the doctor-patient relationship. If I'm a patient and I know you're a volunteer, I can't demand much of you, [since] you're doing me, after all, a favor. I should be grateful. Any complaint would be ungrateful.... But we don't want this kind of contact between a doctor and patient. We want contact that is at least a little empowered.

In Avi's account, "we" was AHE. The organization as a whole was critical of mere charity, and therefore combined it with advocacy for equal access to governmental healthcare. But since AHE's own operational arm relied primarily on volunteers, it could not institutionalize or demand "empowered" contact of its own staff, and therefore failed to realize the entitlement-based care that it most desired for its patients. Aid work at AHE, in other words, remained caught between ideals of universality and preoccupations with conditional worth.

Avi, who was critical of AHE's reliance on charity, pointed out that charity-based medicine imposed conditions on care that a state medical system would not countenance. Patients who complained about their care, for example, violated their benefactors' expectations of gratitude; those whose conditions were chronic and not acute violated expectations of emergency (Calhoun, 2010). Bureaucratic settings would be indifferent to these expectations, but a humanitarian benefactor likely would not be, despite claiming otherwise.

Presumptions of emergency in the humanitarian sphere are often a fantasy (Calhoun, 2010; Redfield, 2010). Writing of asylum seekers in Greece, Heath Cabot argues that situations of need that are framed as anomalous or exceptional "often become protracted and indefinite" (2013, p. 75). Similarly, Peter Redfield (2010, 2014) argues that "at some point, the problems facing the population no longer appear exceptional, however significant they may be. At this

juncture, humanitarian action grows indistinguishable from more general concerns about development and health” (2014, p. 223). Redfield describes, for example, the city of Gulu in northern Uganda, whose population struggled for decades with regional violence and child abductions. At the peak of the violence, MSF set up a shelter for thousands of area children to spend the night in safety.

The shelter had clean sleeping accommodations, latrines, and clinical and psychosocial care; it therefore became highly popular with local families. But once the violence had subsided, the children kept returning daily, taking MSF by surprise. Struggling with whether to close the shelter, MSF staff members wondered whether the children’s kin were reluctant to part with the program because they “rather enjoyed the regular babysitting service” it provided, or “perhaps the children themselves preferred the experience of staying with a lively, fluid group of their peers to facing more restrictive roles at home” (Redfield, 2014, p. 225). Despite the prevalence of emergency narratives, Redfield argues, much of aid consists of more mundane examples like these. In other words, humanitarian responses to emergency become more ambiguous as emergency subsides. Deciding when a situation no longer merits as much attention as burgeoning crises elsewhere is often a wrenching decision for all involved; such is the predicament of the all-too-common verges of crisis.

AHE aid workers faced a similar dilemma. Non-emergency conditions constituted a verge of crisis that tested not only its volunteers’ compassion, but also the organization’s dual aid-advocacy mandate. Was the clinic merely a stopgap solution for medical emergencies, or a struggling medical system working in parallel to an uncooperative state apparatus? If life-saving actions were a source of pride for volunteers, moreover, then chronic conditions tended to elicit more complex feelings. If AHE could not help an asylum seeker with severe ankle problems,

what did this imply about its supposedly unconditional humanitarian mandate? And conversely, if Louisa worked tirelessly to find the woman free or discounted surgery, would a low-income Israeli citizen waiting many months for surgery through the public system not be worth the same kind of attention? Five star service of the sort Sandra provided her patients, admittedly, was rare at AHE. But it was enough to bring to light the irony of aid workers obtaining asylum seekers better or faster medical care through *combinot* than most Israeli citizens could obtain for themselves. “Even Israelis have to wait months for this surgery,” I once heard Uri telling a patient who had called the clinic to complain about a months-long waiting time.

In this chapter, I have illustrated some of the techniques by which AHE aid workers have obtained treatments for uninsured patients, most of them asylum seekers from Eritrea and Sudan. I have argued that such treatments depended largely on AHE’s semi-secret arrangements (*combinot*) with governmental hospitals and bureaucrats, whose involvement in care for asylum seekers has been both altruistic and self-interested. Such treatments, in turn, revealed the presence of patrimonial relations in Israel’s medical bureaucracy, where official economic exclusions belied complex interests in giving some aid to asylum seekers without announcing it widely.

Aid work at AHE, despite being wedded to principles of universality and unconditionality, was irreducibly informed by considerations of which patients were more and less deserving of care (Willen, 2011, 2012). As Susann Huschke (2014) notes, humanitarian aid “is founded on an inequality of lives and inevitably implies the discursive and interactional construction of deservingness... the question of who should receive what kind of care is continually negotiated” (p. 352-353). Compared with the relative stability of government healthcare grounded in the entitlements of citizenship, then, compassion-driven care at AHE was

clearly more polarized. It included actors who would go to extreme lengths to help patients, and others who refused to carry out relatively banal follow-ups or simple treatments. At the organizational level, however, there were curiously few efforts to even out these extremes. In the next chapter, I explore why this was the case by describing in detail AHE's efforts to reconcile its humanitarian and human rights mandates.

CHAPTER 2

COMBINING AID AND ADVOCACY

Helena, a part-time volunteer and university student in her early twenties, stood guard at the door to Activists for Health Equality's free clinic in Jaffa. Her back to the waiting room, Helena faced a crowd of about seventy patients waiting outside, most of them male asylum seekers from Sudan and Eritrea. Some were seated quietly on the sidewalk, but others were openly clamoring to be admitted, holding out hospital discharge letters and imaging test referrals. Like a bouncer at a bar, Helena wedged her body firmly into the doorframe to prevent people from pushing or slipping past her. She held up a crumpled, hand-written sign-up sheet and readied herself to begin admitting select members of the crowd.

Louisa, the clinic caseworker, had instructed Helena to cap the patients at 45 tonight. This number, Louisa thought, was roughly what the primary care doctor, two medical residents, and one nurse on staff this evening could handle. It meant, however, that twenty patients would be turned away, and likely more, since more kept coming. In ideal circumstances, turning away some patients would not be a problem, as the more serious cases would still be caught by the practitioners who did triage, determining patients' levels of severity and prioritizing them accordingly. But to undergo triage, patients first had to get into the triage room, and with a 45-person cap, Helena knew, many would not even get through the front door. This meant that some patients who needed urgent care might remain unattended, just steps away from potentially life-saving treatment.

In Tom Scott-Smith's (2013) study of supplementary feeding programs in South Sudan, the criteria for admitting malnourished people to a program are clear. "At 8am," he writes, "the gate swings open, [and] thousands of children will be measured... Their entitlement will be

determined by a procedure that examines the dimensions of their upper arms” (p. 22). But AHE’s clinic lacked admissions criteria as clear as upper-arm measurements. With the triage room overflowing, decisions of whom to admit often fell to an overwhelmed gatekeeper with no medical training and few guidelines for admitting patients beyond first-come, first served.

Louisa and Rebecca often reassured the gatekeepers that any emergency patients who were unintentionally left outside would eventually make their own way to Israeli hospital emergency rooms. But having spoken with such patients, Helena knew that many of them did not know where local hospitals were located, or doubted they could gain entry there. They looked primarily to AHE for care and had no plan B. Suppressing her anxiety at the task ahead of her – letting in those who most needed help – Helena did the only thing she found reasonable: combining the sign-up list with an improvised triage of her own. First, she scanned the crowd for women, children, and elderly people and called them forward. This elicited immediate protests from men who demanded that she return to the sign-up list. She then scanned the crowd for visibly suffering faces. Watching her grant entry to a young woman who appeared faint, a middle-aged man standing near the door shouted at Helena in anger: “Sister! You are not a doctor! How can you decide who to let in?”

In this chapter, I explore why volunteer gatekeepers like Helena were often left to make such decisions on their own, amidst considerable chaos and protest from patients, when medically trained professionals were only feet away. More broadly, I seek to understand why AHE resisted establishing clear protocols regarding which patients it would and would not treat, and regarding how it might structure their treatment. Focusing in particular on the role of emergency and of failure in shaping this resistance, I argue that AHE’s complex relationship to notions of order and governance has to do with its struggles to reconcile its two simultaneous

mandates: human rights and humanitarianism. Some of the disorder and neglect in AHE's everyday practices of aid delivery, I show, is attributable to AHE's aversions to bureaucratization and quota-setting. These, I argue, posed a threat not only to its advocacy mandate, but also to its complex self-image as an emergency-focused organization.

PATIENTS IN THE DOORWAY

In 2007, the number of asylum seekers entering Israel through the Sinai desert increased markedly, sometimes exceeding 1,000 per month (Omer-Man, 2014). In turn, larger numbers of patients began arriving at the clinic each night. But as AHE's clinic hours or volunteer numbers were not extended, patients increasingly had to be turned away. Some of them resorted to desperate measures to gain entry.

The most popular methods involved the sign-up list. "It's a mafia," said Ronen, a volunteer AHE nurse. Some Eritrean patients, he explained, had been hoarding the list to themselves and denying the Sudanese access to it, and vice versa. Other patients tried to hold or sell spots to what was supposed to be free clinic. Meanwhile, female, elderly, and first-time patients tended to stand quietly over to one side of the clinic door, unaware that there was even a list. After several hours of waiting, they would be told that since they had not signed up, they would not be able to be seen. Realizing this, some of them would make a desperate attempt to get inside anyway by pretending to faint or asking to use the restroom.

Having signed up to "do good" (Fisher, 1997, p. 439), Helena and her fellow volunteers were increasingly dismayed at having to act as barriers to, instead of conduits to, aid. Instead of admitting patients in an orderly fashion, they found themselves arguing with them about whether or not their conditions were severe enough to merit entry, or whether their names truly matched those on the list. Some gatekeepers resigned themselves to such exchanges as an inevitable part

of humanitarian work. “It’s a war,” chuckled Eyal, a writer and editor by day and one of AHE’s more experienced gatekeepers. “Or at least, a battle.”

“If a woman who is clearly suffering [and has not signed up] comes up to me,” Eyal continued, “I’ll tell her to wait on the side and then when others are gone, I’ll sneak her in.” He smiled impishly. “Or I’ll ask someone from triage to step outside for a moment and check if she should be let in. For the others who exceed our quota, I’ll write them notes in Hebrew that they can bring the next day, so they don’t have to wait in line twice. I transfer all my troubles to you!” He laughed, referring to the fact that I did gatekeeping the day after him. “It’s all up to my judgement, no one checks up on me. No manpower to check. I improvise a lot. Sometimes writing notes helps.”

Eyal, then, mostly managed to roll good-naturedly with the chaos. But other gatekeepers struggled to cope with the stresses of turning people away, or became desensitized to patients’ begging. Meanwhile, Louisa and Rebecca, the clinic’s caseworker and manager, respectively, were rarely around to provide guidance. Instead, they were often running between rooms and attending to specific emergencies: a young post-operative patient’s medical imaging disc could not be found, or a diabetic patient had arrived in Jaffa from Eilat on three buses that had taken her the entire day, leaving her children back home. She needed to renew her insulin supply urgently, but no insulin was available, and a colleague with knowledge of where to get more was not answering his phone.

Tending to such problems left Louisa and Rebecca with little time to oversee gatekeepers and other volunteers. As a result, patient traffic was habitually halted, patients needing urgent care were sometimes turned away, and dog-eared medical files were occasionally being

misplaced. The few computers used to register patients were slow and often stalled, and chaotic volumes of angry and desperate people and voices often filled the waiting room.

Overwhelmed by the chaos at the door, gatekeepers and senior staff members had for some years been asking for a better triage system that would take the burden of decision-making away from non-professionals. All it would take, they pointed out, was a single medically qualified volunteer to be stationed outside the door near the gatekeeper, helping to decide who should be admitted into triage now and who should return tomorrow. To an observer, this did not seem like a particularly significant resource drain. There were often at least half a dozen aspiring nurses and physicians on AHE's waiting lists at any given moment. Indeed, sometime a nurse or medical student did pop outside for a moment to examine a member of the crowd who had fainted or who seemed particularly ill; why could this role not become routinized? This question, however, proved more fraught than most volunteers had expected. The reason was that it signaled a potential future change that some aid workers wanted to avoid at any cost: bureaucratization.

RECONCILING AID AND ADVOCACY

The often-fraught relationship between humanitarian organizations and states has drawn considerable scholarly attention. Aid projects, critics have noted, have coincided with numerous military missions, drawing criticism for serving (willingly or otherwise) as a political lubricant in global conflicts (Maren, 1997; Terry, 2002). NGOs have also been widely criticized for unintentionally encouraging or masking the retreat of states from medical and welfare services (Abramowitz, 2015; Barnett & Weiss, 2008; Redfield, 2013; Redfield & Bornstein, 2010). In weak or war-torn states, for example, NGOs have delayed the development of multiple healthcare systems by serving as indefinite stopgaps for care (Feldman, 2009; Redfield, 2012).

State welfare services and humanitarian organizations cultivate markedly different sorts of relationships to their subjects (Barnett & Weiss, 2008; Stein, 2008; Ticktin, 2006, 2011). With some exceptions, state welfare services in developed countries are largely anchored in the exclusionary rights of citizenship. In contrast, humanitarian agencies often profess a concern for all of humanity, deploying a human rights language that affirms the right of all human beings to medical care (Barnett, 2010; Brkovic, 2014; Fassin, 2007ab). In reality, however, aid practices are decidedly more limited than talk of universal rights would suggest (Redfield, 2012b, p. 178). Aid-giving hinges on shifting political agendas and fickle compassion (Redfield, 2005, 2013). It is a form of assistance that is at once deeply informed by ideals of unconditionality and neutrality associated with the Red Cross, and yet is simultaneously concerned, as I described in chapter 1, with questions of conditional worth and of who is most deserving of care (Barnett & Weiss, 2008; Brkovic, 2014; Huschke, 2014; Willen, 2011).

Mindful of the political limits and risks of aid, AHE prided itself on conducting both aid and human rights advocacy work simultaneously. While gatekeepers like Helena struggled to hold back the crowds, two dozen paid human rights workers sat in offices several rooms down the hallway, developing parliamentary lobbying and public advocacy campaigns. Predicated on the notion of healthcare as a universal human right, these campaigns called on the Israeli government to include asylum seekers and other marginalized populations residing in Israel within some rubric of government-sponsored healthcare. As Abigail, AHE's outreach director, put it, using the media was crucial:

If it appears in the media, the politicians get stressed... if a reporter gets interested, then the patient will get treatment. It's a way to bring achievements. For example, we had a cancer patient, and it wasn't in the media, and the [Israeli Defense Forces] wouldn't give him a permit to exit Gaza [into Israel for treatment]. We begged, we sent [the IDF] a letter, got a medical opinion, blah blah blah, nothing worked... but suddenly, Amira

Hass¹⁹ writes an article about it or just sends a “how come?” to the IDF spokesperson, and boom, the man is out. Or if there was an article in *The Guardian* or in *The New York Times*, it pressures the Ministry of Foreign Affairs, and the Ministry pressures the IDF, and the IDF gives in.

Abigail’s description of media use referred primarily to short-term gains, but as she herself conceded, governmental policy reform was considered the most important goal. Fatima, an AHE human rights worker, explained why policy reform mattered, and why AHE could not focus only on aid:

AHE has never claimed to be only humanitarian. Humanitarianism gives rights only to the poorest in society; it does not address the entire civil body. It’s exclusionary treatment. There’s no treating you as a whole human being here. What is being recognized is just horrible suffering. It is *political* situations that create and exploit humanitarian situations. Governments will make cynical use of the term *humanitarian*. Israel will say, for example, ‘I let 40 patients enter Israel’ while sweeping the broader occupation issues under the rug.

As Fatima argued, humanitarian aid was depoliticizing: it came at the cost of reducing political complexity to medical simplicity, and political actors to helpless bodies; this was why, she said, the clinic’s aid work in the immediate present needed to be balanced with long-term human rights advocacy. AHE was ultimately striving for medical care that was entitlement-based, not compassion-based, she explained. Her argument recalled global critiques of aid, notably Didier Fassin’s (2007ab) analysis of humanitarianism as reducing those that it saves to bare life, lacking in any political voice or agency. The delivery of aid, Liisa Malkki (1996) has similarly argued in her seminal work on refugees, is dehistoricizing, often rendering its beneficiaries mute and reframing their plight in ways that “leach out the histories and politics of specific refugees’ circumstances” (p. 378). And as Ilana Feldman (2009) has noted in her work on humanitarianism in Gaza, aid is often given to recipients while “requiring them to appear as exemplary victims and not political actors in order to receive recognition of their suffering” (25).

¹⁹ A prominent Israeli left-wing journalist who writes mainly about the Palestinian Territories.

AHE's veteran volunteers and employees were familiar with the broad tenor of such critiques, and drew upon them often to emphasize that they were not merely giving aid, but had more ambitious goals in mind.

AHE's media and donor reports often presented the organization's dual aid and advocacy mandates as complementary: "we treat patients in the here and now," reports often indicated, "while lobbying to improve their futures." In practice, however, these mandates often clashed. Providing aid for Israel's uninsured populations, AHE staff members knew, lowered the pressure on the Israeli government to assume responsibility for them. "AHE's informal networks are like a collaborator or fig leaf for the Ministry of Health, just like pro-Palestinian Israeli NGOs are a fig leaf for the occupation [of the Palestinian territories]," explained Uri, a veteran volunteer who helped to improvise diagnostic tests for patients. "Instead of letting people die in streets, we keep things on low flame. By getting people care informally, we are keeping the crisis down," he concluded with sarcasm.

There were significant problems, in other words, with providing asylum seekers with healthcare on a non-governmental basis while the Israeli government conveniently looked the other way. Not only was humanitarian medicine limited by the finite compassion and interest of volunteers and donors, but it also tended to frame medical treatments as matters of kindness to the downtrodden rather than of justice for all. Lilie Chouliaraki (2010) argues that pity has enabled "the alleviation of suffering among large populations in modern times;" at the same time, she argues, "it has simultaneously established a dominant discourse about public action that relies heavily on the language of grand emotions about suffering" rather than on a "long-term concern with establishing structures of justice" (p. 108). AHE staff were similarly aware of the ways in which immediate bursts of compassion could undermine long-term political action

(Barnett, 2003; Bridges, 2010). Over the course of endless staff meetings, board meetings, and private conversations, they debated the ethics of giving aid at the expense of advocacy, and vice versa – reaching no clear resolution and writing no clear-cut policies regarding which would be prioritized .

Over time, a dichotomous understanding of AHE’s dual mandates emerged among AHE staff and volunteers. According to this understanding, human rights advocacy was a form of political activism that aimed for stable, entitlement-based governmental healthcare services for asylum seekers. Some AHE staff members felt that this advocacy was, or should be, AHE’s main mission, whereas humanitarian work was to be its hand-maiden, a conditional, compassion-based and short-lived form of assistance for those patients who could not afford to wait for policy changes to take effect (if they ever did). Each form of aid, the organizations’ members recognized, was required to attend to a different kind of medical need, and each was presumed to have its strengths and weaknesses as a response to inequality. A delicate balance among the two was seen as necessary, although how an ideal one was to be constructed and defined among the two differed markedly among individual staff members. Some sought a strong aid emphasis, and others, a stronger advocacy emphasis.

Yet even this presumed dichotomy between humanitarianism and human rights advocacy proved fragile. First, the equation of human rights advocacy with long-term gains was by no means assured. The international human rights discourse has repeatedly come under attack over the past several decades by critics on the left who view it not as the longed-for paragon of redistributive justice for the downtrodden, but as a conservative tool that relies on international legal instruments, like the 1951 UN convention, to deliberately keep the number of officially recognized refugees small. The reason is that only a small minority of all asylum seekers would

meet the strict criteria of individual persecution as they are laid out in the 1951 convention, or could prove to an asylum officer that they do, using documentary evidence or carefully honed narratives of persecution (Van Hear, 2011). As Zach Manfredi (2013) notes in his review of critiques of human rights, critics working “in the Marxian tradition have diagnosed [the human rights discourse] as nothing more than an ideological revision of nineteenth-century bourgeois rights that re-entrenches class exploitation and oppression” (p. 5). Meanwhile, Manfredi continues, “feminist critics have noted the limitations human rights impose by naturalizing a masculinist notion of an unencumbered and self-sufficient subject as the model rights-holder” (2013, p. 6). In other words, it is individuals, not communities, who must prove that they are being individually targeted in order to qualify for asylum. The human rights approach to health, then, has been critiqued as embodying an “individualist and legalistic-reductionist” worldview that tends to ignore structural factors in the reproduction of global inequality and does little to mitigate their harms (Filc, Davidovitch, & Gottlieb, 2015, p. 91; see also Castañeda, 2011; Yamin & Cantor, 2014). Indeed, for some critics, the individualistic stance of human rights advocacy means that the latter is ironically depoliticizing, since it ignores broad questions of racism and structural discrimination (Filc et al. 2015; Leebaw, 2007).

Other critics have pointed to the maximalist overtones of human rights activism, asking whether such activism has gradually become divorced from what it really takes to implement a “human rights-based approach to health” in daily practice. Alicia Yamin and Rebecca Cantor (2014) suggest that human rights activists are adept at speaking broadly of the entitlement of humanity to healthcare, but are loathe to address where the resources for such care would come from, or what budgetary sacrifices might be necessary to make such entitlements a reality:

[I]t is all too easy to call for the laws and policies to be changed to be consistent with the theoretical requirements of human rights; what is far more complex is to understand the

dynamics that prevent effective enjoyment of human rights on the ground... Abstract claims to devote ‘maximum available resources’ to the right to health are unlikely to get us very far in convincing health policymakers and ministers of finance in making the tough choices that are required in allocating inevitably scarce resources... Yet these choices are often unfamiliar to human rights activists or imply eroding the sanctity of the principles (p. 463, 466).

Yamin and Cantor’s description alludes to human rights organizations’ reputation in certain activist circles for being somewhat removed from everyday reality. Numerous AHE members, indeed, spoke to me with pride of AHE not being “simply” a human rights right organization, but of having its metaphorical two feet firmly on the ground by virtue of treating patients, not simply writing advocacy briefs about them from a distance. Treating patients, they explained, connected AHE members to the former’s daily problems and challenges in an immediate way that other human rights organizations could not lay claim to. “Unlike other human rights organizations, which deal with theories,” said Abigail, AHE’s outreach director, “we deal with the live flesh, and it makes us go down from the theories to the reality.”

Thus, human rights activism is not necessarily the sustainable opposite to immediate humanitarian action. This is not merely because of the former’s widely criticized individualism or limited engagement with structural violence. Rather, numerous organizations have themselves increasingly blurred the boundaries between the two forms of action by drawing on both of them simultaneously, whether by utilizing compassion-eliciting references to suffering in human rights campaigns, or by bolstering aid missions with human rights terminology. AHE, in other words, is not unique. Médecins Sans Frontières (MSF), which was founded in 1969 by French doctors (Redfield, 2013), was arguably the first NGO to explicitly seek a basis for humanitarian action that was not pity or charity, but political action and protest (Leebaw, 2007). At the time of its founding, MSF protested the collective inaction of global powers, which permitted the devastating famine in Biafra, Nigeria to continue. The idea of bearing witness to

injustice, and of reporting it to the world, gradually became as strongly synonymous with MSF's mission as was its aid work.

Other international aid organizations have since followed suit, forming what some scholars have called a “new humanitarianism,” meaning a humanitarian engagement that cares about politics and seeks to intervene vocally in it in various ways, ranging from acts of witnessing and protest to entry into war zones without the permission or consent of local governments (Filc et al., 2015; Leebaw, 2007). Indeed, various humanitarian “best practice” recommendations, some of them endorsed by the UN, have encouraged aid organizations worldwide to adopt a human rights framework in their daily operations (Leebaw, 2007). Notably, there is some slippage in this discourse among “human rights” and “politics:” in some accounts of the new humanitarianism, human rights advocacy is considered a form of political engagement. In others, however, particularly those that fault human rights discourses for neglecting structural violence, human rights activism is considered an impartial action, and “political” is reserved for those organizations that take an explicit stance on particular conflicts (Leebaw, 2007).

The increasing involvement of humanitarian organizations in politics has drawn concern among critics and practitioners alike. Some have been resolutely in favor of such a transition, insisting that physicians and medical organizations must be committed not only to saving lives, but also to combating the social conditions that lead to death and suffering (Filc et al., 2015). Others, however, have pointed out that neutrality is vital to ensuring access to victims in need of urgent care (Leebaw, 2007). For a third set of observers, meanwhile, impartiality and neutrality are themselves a fiction, for they see aid work itself as inherently political: after all, aid, they point out, draws attention to atrocities, reallocates resources to those in need (thereby often

changing the facts on the ground) and refuses to allow corrupt and genocidal governments to isolate their citizens from life-saving assistance (Barnett & Weiss, 2008). Regardless of which view holds more merit, the question of how NGOs are to position themselves vis-à-vis global politics, and whether they are to remain impartial or engaged in conflict, carries increasing weight in an age where NGOs provide an ever-growing share of resources not only in poor countries, but in wealthy ones, as well (Filc et al., 2015). AHE members were largely aware of these critiques and debates, and their discussions indicated that they knew that at stake in their advocacy-aid balance was not simply the lives of their current patients, but also the inclination and ability of the Israeli government to increasingly outsource welfare services to non-governmental actors and to commercial providers, even when it pertained to its own citizens (as exemplified by the increasingly privatized governmental healthcare system).

In 2007 and 2008, the incoming wave of sub-Saharan migrants and asylum seekers posed an important challenge to AHE's existing efforts to balance aid and advocacy. Over 100 patients soon began showing up at the clinic each evening, compared with the 20 or 30 to which practitioners were accustomed. The latter were soon so overwhelmed that a series of emergency meetings was called. How can we treat all these people? aid workers asked. Should AHE open new clinics in other cities? What logistical challenges would this entail? And how could AHE maintain its advocacy momentum if it developed the reputation of a comprehensive service provider?

Most of AHE's employees and volunteers could not imagine AHE, a politically vocal organization with a strong activist bent and history of anti-governmental opposition, transforming into a bureaucratized network of clinics. As many of them saw it, such a transformation, even if possible economically, would undermine AHE's political mandate by

rendering it aesthetically and functionally indistinguishable from government clinics. At the same time, without aggressively recruiting additional resources and volunteers, AHE risked forsaking many of its new patients.

In spring of 2008, unable to cope with patient loads, AHE abruptly shut down the clinic for three months. During the closure, patients with chronic and life-threatening patients continued to be quietly treated. As Abigail, the clinic's outreach director, put it, "we did take diabetic patients in behind the scenes, because was very hard for doctors to think they were leaving patients without anything." Yet the clinic itself was largely closed to walk-ins for three months, a radical decision that would have seemed unthinkable to many during the months prior to it, as well as after the clinic's reopening. During those three months, in a shrewd advocacy move, some of the patients who arrived at the door were bussed to government hospitals nearby, where they caused immediate bottlenecks and widespread panic in the emergency rooms – exactly what AHE had wanted.

Within days of the AHE clinic's closure, the Israeli Ministry of Health scrambled to offer AHE a considerable sum of money²⁰ to reopen the clinic and resume its care for asylum seekers. AHE declined, but saw in this offer a triumph – an acknowledgement by the government that their work mattered and that asylum seekers needed medical care. By this point, most AHE staff were in favor of reopening the clinic, but few wished to accept government money for it. "Accepting the money was absolutely forbidden, this we could not do," explained Avi, one of AHE's founders, in spring of 2012. "We could not be the Ministry of Health's contractor on this issue, because it opposed our view about including refugees in the [state] system," he said. Instead, AHE was hoping their political momentum would help pass a bill in the Israeli Knesset

²⁰ Two high-ranking AHE staff members casually stated that the amount offered had been 500,000 NIS, yet others, citing confidentiality concerns, would neither confirm nor deny this amount.

that would grant asylum seekers entry to the national sick-fund healthcare system. These efforts failed; in their stead, the Ministry of Health asked the Israeli Medical Association to open a small medical clinic for asylum seekers in south Tel Aviv.

The new clinic took AHE by surprise, and immediately became a foil to AHE's own clinic in Jaffa just a few miles away. Was this all the government was willing to offer? AHE staff wondered. Clean and well-appointed, the new governmental clinic ran primarily by appointments, contrasting markedly with MHE's chaotic doorway gatekeeping. The new facility's rent was paid for by the Ministry of Health, which was widely read as a partial admission by the government of its responsibility for asylum seekers' healthcare. But its staff was itself comprised of volunteers, and it initially held no formal links to more advanced governmental treatment channels. AHE doubted whether the new clinic's masterminds had any serious intentions of developing the same array of arrangements or *combinot* that AHE itself had painstakingly cultivated in order to obtain specialized care for its patients. It was not clear whether this clinic could treat chronic or life-threatening conditions that did not qualify for emergency room care.

Reading the new governmental clinic as a cynical attempt to distance asylum seekers from the government healthcare system in the guise of a token humanitarian gesture, AHE redoubled its protests and re-opened its own clinic in Jaffa. The new governmental clinic, they insisted, could not provide comprehensive care for a population of over 50,000 asylum seekers and 100,000 or more undocumented migrants. But AHE's clinic re-opening came with few new decisions regarding its own present and future capacity. The same medical files continued to be misplaced even as volunteers credited another successful treatment to their widespread *combinot*. Aid actors careened from tireless efforts to save lives to misplaced medical files.

There was no shortage of memorable successes to offset the failures and keep aid workers' morale high. In early 2010, for example, Sandra, a 30-something oncologist and part-time volunteer with AHE, spent each morning looking for Germay, a 19 year-old Eritrean asylum seeker with advanced Hodgkins Lymphoma. Every morning that spring, she drove to the north Tel Aviv construction site where he worked and parked her car on the sidewalk. Exiting with a donated chemotherapy injection in her hand, she would shout up to Germay to come down from his fifth floor scaffolding. When the spritely young man descended and bent over, Sandra administered the daily injection in his buttocks before waving goodbye and speeding off in her car to her hospital shift.

Stories like this one, which Sandra told me herself and which I heard others repeat, earned an important place among AHE's foundational myths. The image of a rogue doctor rushing to a construction site to administer chemotherapy captured precisely the kind of aid Sandra's colleagues perceived themselves to be doing: intervening in an urban space marked by exclusion, and bringing last-minute life-saving treatment to those who toiled on the fringes of society, untreated and forgotten. Sandra's work emerged out of these shadows as a form of civil disobedience, a concept that many AHE volunteers appreciated and enjoyed attributing to themselves; she was refusing to let the man die while protesting her society's indifference to its weak and downtrodden. This particular narrative – successfully administering chemotherapy outside of a hospital setting – not only painted Sandra as a lone hero, engaging in valiant life-saving with seemingly little, if any, help from colleagues, nurses, bureaucrats, or hospital beds. Rather, it also stripped away the nuisances that often accompany such treatments in real life: high costs, crippling side effects, and uncertainty about success. It helped, of course, that the young man seemed curiously energetic for someone suffering from advanced lymphoma; he was

still working in a physically demanding job, and the daily chemotherapy injections did not seem to faze him.

The significance of such life-saving acts at AHE made the organization's habitual negligence more perplexing to newcomers and veterans alike. How could tireless life-saving co-exist alongside missing patient files and gatekeepers who had no medical training? Yet this impasse persisted; however simple it may have seemed, to a casual observer, to increase patient quotas at AHE's clinic and put a medical volunteer at the door, such actions, in eyes of others, would amount to a political concession to the Israeli government.

AHE's competing mandates created complex ethical dilemmas for aid workers who wanted to treat as many patients as possible. These volunteers, whose day jobs in the Israeli medical system accustomed them to relatively clear criteria for exclusion and inclusion of patients, struggled to accept the higher degree of uncertainty at AHE regarding who did and did not fall within a "treatable" category. As Peter Redfield (2013) argues, it is difficult to sanction illness and death within a humanitarian framework, and AHE's frontline volunteers, in particular, struggled to countenance it.

I often asked aid workers whether they thought a medical professional should be put at the entrance to help with admission and make sure severely ill patients were not left outside. Most said yes immediately, proceeding to complain about the status quo. But Abigail, AHE's outreach director, who took a wider view of the organization as a long-term full-time employee, had a strong negative opinion in the matter. "Every volunteer," she pointed out, "means one additional person who trains him. Who hears his complaints, who improves his work, who schedules him. It's unavoidable." Recruiting additional volunteers, she argued, "has a price. If you get more volunteer doctors, the price of that is that you do less advocacy." It meant that

“more and more of the organization’s resources, conversations, discussions, and members will be drawn to this aid,” she explained. “The more ‘humanitarian’ you do, and ‘humanitarian’ has its charms, you will not be able to keep a balance with advocacy.” In the following section, I examine these tradeoffs in greater depth by describing how two AHE volunteers, Oren and El’ad, clashed bitterly over how many patients the clinic should treat. Capturing important tensions within the organization, their disagreements often manifested in what appeared to be arbitrary fluctuations in aid.

ARBITRARINESS AND COMPASSION FATIGUE

During one evening shift, Oren, an energetic medical resident who always seemed to be in several places at once, asked me to forget about the 45-patient limit. He wanted to let everybody into the clinic without telling Louisa, who he knew would surely dispute it. “We’re a strong triage team today, we’re efficient, we’ll do good, let them all in!” he said eagerly, standing on tip-toe at the entrance of the triage room and glancing out at the crowd of people waiting on the pavement. “We can work quickly and see everyone; no need to turn anyone away,” he insisted.

El’ad, Louisa’s 19 year-old volunteer assistant, overheard Oren from the other side of the waiting room, which was increasingly getting more and more crowded. With only 16 plastic chairs in the cramp room, most patients had to stand; there was little floor space. El’ad pushed his way over through the crowd and told Oren, “Absolutely not. What about referrals? We don’t want them to stay till midnight! I won’t burden them like that, it isn’t fair.” He was referring to the two volunteers in the other room, who regularly fed hand-written referrals into the rudimentary computerized tracking system. “Most patients won’t need referrals, though, right?” Oren responded. “Some might,” El’ad insisted.

Oren and El'ad argued for a few minutes. Once Oren had seemed to capitulate and El'ad had left, Oren nevertheless mischievously grabbed my sign-up sheet and whispered, "let them all in." He grabbed a startled young patient's arm and pulled him into the triage room for emphasis, saying to him, "Come! Come!" A couple hours later, El'ad returned. Seeing the crowds dwindling fast, he was furious, berating Oren for his dishonesty. "He's naïve and he's disruptive," El'ad later complained to Louisa, insisting that Oren be educated in the ways of the organization. It was easy for Oren to let them all in, El'ad pointed out; Oren was only around 2 or 3 shifts per month, and had little idea of the delicate balance AHE was trying to achieve between aid and advocacy.

El'ad struck me as precocious but highly cynical for a 19 year-old aid worker. Watching him complain to Louisa, I wondered whether the more important difference between El'ad and Oren might be less the former's lengthier schooling in AHE's aid-advocacy balance, than the fact that Oren had not been around long enough to develop compassion fatigue. Human rights scholars have described a "culture of martyrdom" among human rights and social justice workers and volunteers (Chen & Gorski, 2015, p. 366). In particular, they have pinpointed the sense prevalent among many workers in this field that tending to their own well-being violates their prior commitments to alleviating the ills of others. While emotional burnout is prevalent in numerous professions, in the humanitarian and human rights spheres it assumes a unique form due to the burden that the worker has willingly assumed to care diligently for those whom society has excluded or forgotten (Pines, 1994). Tending to oneself reeks of selfishness to those who have had to significantly adjust their thresholds of discomfort, tolerating difficult work conditions and a relative or total lack of monetary compensation in order to realize an idealistic mission to rescue the downtrodden. When burnout occurs, it manifests in both disillusionment

with one's capacity to save others and often, too, a guilt-ridden sense of indifference or anger towards those whom one has pledged to save. El'ad demonstrated this well. He had arrived at the clinic only a year earlier, and I remembered him acting excited and humbled to be taking part in humanitarian work. By the time of our first interview several months later, however, his idealism had eroded significantly, and he appeared to have internalized some of AHE's grim trade-offs in a mechanistic way.

"The clinic will always be faulty and damaged, and will always be lacking in resources," El'ad said to me in an affect-less monotone, adding that this was how AHE meant things to be. He spoke as if delivering a lecture he had given many times before, and indeed he had, he said; I was one of over a dozen graduate students and journalists who had recently interviewed him about his work. Softening his tone a bit, he then shifted to a more personal register. "Even though I live inside all these difficulties at this moment," he said, "this is how it should be at the end of the day. It's unpleasant for those who are volunteering or working at the clinic, but it can't be any other way."

El'ad's descent into cynicism was noted by his peers. "He's a boy!" said Ilana defensively, the clinic's former manager, who was still fond of him despite his increasing surliness. "He's an 18 [sic] year-old boy, and he's burned out and exploited and has way too much responsibility." Once, she added, he had "snapped and told the others, 'I'm 18 years old. You expect me to tell a 70 year-old Filipina if she should go to the emergency room or not? Have you lost your minds?'"

No one lasts a long time doing this kind of work, Ilana added. She herself had stopped managing the clinic, she said, once she realized her own attitude had changed from "love and patience for asylum seekers to wanting to spearhead their massive expulsion myself." When she

first started as manager, she said, “I would have a nervous breakdown over every patient’s runny nose.” But gradually, she recalled, “I stopped caring even when they were dying of cancer. It was then that I realized I should not be doing this kind of work anymore.” I asked whether some emotional distance was not actually helpful in this kind of work. “It is not,” Ilana responded matter-of-factly. “I think the people working here²¹ should be passionate about the job. They should give it their maximum, should open their hearts and not just give a certain number of hours per week. I felt I wasn’t working for the good of the patients anymore.”

Volunteers who only came once or twice a month typically lasted longer at AHE than those who volunteered or worked there full-time. Louisa and Rebecca, for example, both stayed at AHE only about three years before quitting. In addition to the long hours and low pay, they spoke of feeling as though they were being continually being set up to fail, and could never truly succeed: there were always patients who would be turned away, who could not be treated, or who might have been treated in slightly more generous milieus. Whether a particular shift, day, or month was a “generous” one or not seemed, over time, to be arbitrary.

Meanwhile, most patients did not know or care that the clinic’s aid workers, with the exception of Louisa and Rebecca, were all volunteers. Patients, rather, largely assumed AHE was a governmental clinic, and protested its exclusions as readily as they protested Israeli asylum policies. As a gatekeeper, for example, I was once told by two angry patients that I should be fired from my job. Indignant and exhausted, I could not help but snap in response that I was a volunteer, at which the patients both snorted. As 19 year-old El’ad pointed out,

Many patients look at us as they would at a governmental institution... Israel to them is NGOs and it’s immigration police. For many patients, these are on the same scale, which is disappointing sometimes. At the end of the day we do give free medical care, which is something that any person will appreciate. But at the same time, this clinic is full of disappointments. When a patient doesn’t get an MRI, for example, which is something

²¹ Ilana said “ovdim”, a Hebrew word for “working,” but was clearly referring to both paid and volunteer work.

that we usually can't fund, then if he's angry, he'll often not look at us as a human rights clinic, but rather as an *Israeli* clinic. As far as he's concerned, we're something hostile and not sympathetic.

Some aid workers reconciled themselves to patients' habitual resentment, but Abigail found it unacceptable. It was vital, she argued, that patients be told that AHE was not part of the government. "Even if they don't care, it's our duty to tell them over and over... they should know they're dealing with volunteers, even if only as a matter of calibrating expectations and of honesty. They need to know what they've gotten themselves into."

Veteran aid workers' compassion fatigue contrasted with the idealism of volunteers like Oren, who arrived only once or twice a month, and Sandra, who never seemed to tire of tracking down her oncology patients and making sure they made it to treatment. These highs offset the lows of more detached aid workers, and made many of the clinic's successes possible. At the same time, the "idealists'" impressive capacity only underscored the arbitrariness that seemed to accompany life-saving at AHE. During his shift, Oren's team had treated nearly 70 patients, and much to my personal relief, no one had to be turned away. Yet it was a painful reminder to everyone present that the dozens of patients who *had* been turned away on other nights might have been treatable, after all. AHE's most painstakingly rationalized limits, in other words, seemed both inevitable and arbitrarily imposed.

Oren and El'ad's dispute provides an important clue regarding why debates about putting another volunteer at the door tended to drag on without resolution: namely, different aid workers adopted different approaches to AHE's dual aid-advocacy mandate. Settling on a specific quota of patients to treat would require, first of all, reaching some kind of compromise on where to draw a humanitarian maximum and minimum, and during my fieldwork, AHE by and large did not reach one. Aid workers like Oren sought to maximize aid whenever they were present, while others like El'ad would counter with warnings of missed political opportunities. In some

instances, El'ad's contrariness admittedly seemed more a reflection of his own compassion fatigue than of a well-considered argument. His weariness and frustration, indeed, reflected a growing disillusionment with AHE's aid-advocacy aspirations as a whole, and growing skepticism regarding the possibility of winning on either front.

Yet confusion about how to combine aid with advocacy was not merely the product of compassion fatigue or cynicism: new volunteers and veterans alike struggled to marry the two mandates. In particular, when faced with angry or deceitful patients, aid workers seemed to forget about the universality prong of their mandate – ostensibly presuming that healthcare was a universal human right – and reverted almost without noticing it to a gift logic that expected gratitude and humility from aid recipients.

One day, for example, a long-time patient came to the clinic to find that his thick medical file had been misplaced. He was stunned: he was due for surgery soon, and the file contained years' worth of prior treatments and testing results, none of which had been backed up in paper or electronic form. When an overwhelmed young volunteer offered him little more than a brief apology and a distracted suggestion that he go to her colleague to open a new file, he exploded in anger. He could not afford to wait for these tests to be repeated or for the results to be re-ordered, he explained to her in limited English. Refusing to move from a crowded spot between the waiting room chairs and the reception desk, he insisted he would remain there until they found his original file.

From the young volunteer's perspective, however, a lost file was nothing exceptional. Files were misplaced daily, and many of them did turn up again at some point; perhaps a volunteer had placed his in the wrong bin, and there were dozens of bins and over 30,000 current files. Without a protocol to follow for situations like these, and juggling the simultaneous

requests of several patients, she found the man irritating and attempted to ignore him. She flitted back and forth in the crowded, noisy room, restarting malfunctioning computers and hastily registering new patients. Seeing that the man had not moved his gaze from her, she berated him for continuing to stand there and asked him again to open a new file, to serve him at least until his old one were found. He did not budge. Minutes later, she escaped to the small kitchen and complained to two fellow volunteers about the man's sense of entitlement. "Who does he think he is? Doesn't he realize we're volunteers?" she asked incredulously. The irony of faulting a man's absent gratitude in a clinic presumed upon the notion of a universal entitlement to healthcare, had seemed to escape her.

Veteran patients frequently noticed that patient quotas and admissions criteria at the clinic were not always consistent or seniority-based. During one gatekeeping shift, for example, I noticed that a man holding ticket number 36 favored a hand whose bandage was stained with fresh blood. Only 12 patients had seen been through triage by this point, and clinic time was dwindling. Sitting not far from me on a plastic chair, the man seemed calm, but I had no idea how severe the wound was. Worried that with a number 36 ticket he would never get to a doctor, I eventually decided to quietly sneak him into the triage room after the next patient, hoping no one would notice.

A barrel-chested man holding a number 14 ticket did notice, and quickly jumped to his feet. "The numbers don't mean anything! Why does he get to go in?" he cried out in English, pointing at the bandaged man's disappearing back. Unprepared, I unceremoniously blurted out that urgent cases had priority, and that the medical staff would soon have to leave for the night. Realizing abruptly that he was being thereby deemed "non-urgent" and might be sent home empty-handed after many hours of waiting, the man exploded in anger. His chest was hurting,

he said, and he had nearly fainted hours earlier. “Maybe my pain is less visible, but that does not mean it can’t be worse than theirs. It is worse!” he shouted, his voice reverberating throughout the room. Patients sitting around him, having themselves waited over 5 hours, scarcely reacted.

Realizing that they faced either a stingy or quasi-arbitrary admissions process, some patients resorted to varied techniques of resistance. Some, for example, noticed that those who only needed a medication refill were sometimes quickly admitted into the triage room without a ticket in order to receive medication and then leave. These patients soon learned to persuasively say that they only needed medication in order to obtain a quicker audience with a nurse. “Who can blame them,” Ilana sighed. During her years as clinic manager, she explained, “I would have to stand there myself and judge who looked the most pathetic [*misken*] of them all, and then decide if they’d see a doctor or not. And yes,” she added, “some people would say ‘I can’t breathe,’ and I’d let them in, and in reality they’d have a heartburn. Or they’d stake out a prime spot in the hallway near the treatment rooms and as soon as a patient left, they’d leap inside. Sometimes I’d let them have their way,” she sighed. “Sometimes I’d get upset, sometimes I’d say no, and sometimes the doctors themselves would get angry and go home.”

Such scenes were not exceptional. Nor was it difficult to imagine them occurring in a governmental medical clinic. However, it was their casual persistence, and the lack of organizational efforts to instill order in the triage system and expand staffing or hours, that nurtured a growing cynicism among frontline volunteers themselves. Instead of clear-cut policy or even partially articulated mandates of care, chaos and disorder continued to accompany successful against-all-odds *combinot* and treatments. Some of this disorder did seem merely a function of language barriers and limited resources; but even “limited resources” was a contested

concept. It would not have been impossible, frontliners knew, to recruit a medical volunteer to stand outside the door or to extend the clinic's hours, yet during my fieldwork, this was not done.

Adí, a veteran volunteer, and her peers were outraged by this status quo, insisting that any triage that took hours to complete was not real triage. "We should be standing outside and asking them what ails them!" Adí told Louisa, the clinic caseworker. "We do," responded Louisa, sounding unconvinced. "If they need pregnancy tests we send them straight to referrals. If they have blood work results with them we let them skip triage and go to the doctor." That's not enough, Adí replied. Most people, she pointed out, simply stand outside begging to come in: "They just say 'doctor' when we ask what they need." We should ask them more specifically what they need, she continued, so that they're not let inside only to remain forgotten there for hours.

"It's not feasible to get this information from them outside," Louisa responded, "and it's also problematic ethically, since others can hear them. We need to bring people into the clinic as fast as possible." It did create a bottleneck inside, she acknowledged, but an *administrative* bottleneck inside was better than a *human* bottleneck outside, where people might get into fist fights. "Fist fights?" Adí replied in surprise. Louisa nodded, sighing. "You know when I most feel like quitting this job?" she asked of no one in particular. "When I feel like a Nazi telling sick people to go home out there, that's when I want to quit. It's a terrible system." Louisa closed a patient's file and took off her glasses, rubbing her eyes slowly as Adí left the room.

"In the first hour it's a shock," said Guy, AHE's volunteer psychiatrist, while reflecting upon his first visit to the clinic. "People are sitting there in the waiting room in really crowded conditions. And suddenly you feel like you're in another place in the world, in Africa," he chuckled, seeming embarrassed. "I also feel uncomfortable going past them as if I possess a

superior claim to the place. I'm the doctor, so I'm not one of those who need to sit there in that terrible lineup, fighting each other to get in," he added. "They can't always get in to see a doctor. It's a difficult feeling that raises nearly unconscious racist reactions. Me, them, we, them."

AESTHETICS OF AID

In April 2012, I visited the Ministry of Health's gleaming new refugee clinic. Arriving an hour before the clinic opened, I crossed spotless parquet floors to wait for the coordinator. The clinic, just over four years old then, exuded a sanitized dental office aesthetic that invited immediate comparison with AHE's peeling paint, broken plastic chairs, 1990s computers, and dirty examination beds. The contrast was at once astonishing and disturbing. Could AHE have created such an orderly space? I wondered as I took in the orderly rows of plush waiting room chairs.

Before my visit to the government clinic, AHE aid workers had cautioned me not to make too much of its cleanliness. It looked great, they acknowledged, but medically, it was "way more limited than we are," as El'ad put it. "The guy who works there is really nice," he continued, "but they don't make arrangements for surgery." Other AHE volunteers agreed, adding that this new clinic had no translators and would not accept any walk-ins.

Yaniv, the clinic coordinator, was indeed a friendly, energetic man in his mid-thirties. Within minutes of my arrival, he was making us both hot chocolate in the clinic's small kitchen, assuring me that he was an employee, not a volunteer. He was getting paid to do this job, but not much, he winked. Social medicine, he added, was his life's passion; he had come here from another community clinic and was determined, he said, to build a similar space of inclusion here

– a statement I found ironic in view of the auspicious circumstances surrounding the clinic’s creation.

When I mentioned I was volunteering with AHE, Yaniv’s demeanor suddenly hardened. He appeared to feel almost betrayed by the revelation, and the atmosphere in the room abruptly shifted. Activists for Health Equality was a smug, anti-institutional, and hypocritical organization, he said, sitting a bit more stiffly than he had been a moment ago. It’s not us who disrespect and neglect patients, he continued; it’s AHE.

“In this clinic,” he explained, gesturing at the still-empty waiting room around us, “you call to make an appointment. It’s very simple, and not overwhelmed with ideology. When you pass by [during our shifts], you don’t see the chairs all packed with people, do you?” Yaniv then said that AHE enjoyed keeping people outside by the masses, not by necessity but by choice. He intuited well AHE’s aversion to becoming a hum-drum clone of a governmental clinic, and made it clear to me that he considered this position a mistake that played with patients’ lives in the name of politics.

“We are missing out if we make them wait outside like cattle. They deserve a choice about how long to wait,” Yaniv said. Disputing rumors that he had no translators and would not accept walk-ins, he nevertheless declined to elaborate on how many volunteers he had or whether his team could treat cancer and diabetes, saying he did not want such information to get back to AHE. Instead, he preferred to stress the normalcy and order that prevailed at his clinic, as it did, he said, in any other governmental clinic: “patients make an appointment for 2-3 days from now. We give them a choice – they can either see a nurse now or a doctor later.”

His clinic, he continued, did not mimic AHE’s paternalistic attitude towards patients. Patients who came in late were not allowed in. Moreover, he added, “if they need a follow-up,

it's their responsibility to call back in a month to make an appointment. I'm not going to chase them down. You need correct, efficient management here. We don't want patients to be frustrated." Noting my skepticism about whether patients could handle such responsibilities, he said, "*you* try pushing people to get a spot [like at AHE], see how *you* feel. AHE's triage is horrendous. No respect for human rights. Here we prefer that they don't wait an hour. We prefer to *listen* to them... It's man to man, it's eye level. If they make appointments they can also sit inside like human beings, with dignity." He explicitly requested that I relay his comments back to my peers.

Yaniv's deft blending of bureaucratic language ("correct, efficient management") and the presumption of rational patients making free choices, on the one hand, with notions of dignity and human rights, on the other, inverted and mocked AHE aid workers' own uses of the latter terms. In his usage, "human rights" indicated a concern for individual patients' dignity, yet unlike at AHE, such dignity pertained primarily to how appointments were obtained, not to the broader context of asylum in Israel.

Hearing Yaniv's critiques upon my return to the clinic, several AHE staff members grudgingly acknowledged his points. But others reacted with a mixture of defensiveness and contempt, scoffing at his suggestion that he was treating patients with respect while they were not. "If [the new governmental] clinic is just there to treat the poorest of them without advocating on their behalf, there's no point to it," said Tom, AHE's executive director. Yaniv "doesn't understand the political complexity of his clinic," Louisa concurred in a separate conversation. "His approach is very humanitarian. He has a bit of a budget, and he works exactly like we do, with volunteer doctors," she added, inflecting the word *humanitarian* with mild condescension. "It's not as though the Ministry of Health has taken responsibility for this

population. It's a perfunctory step [that] doesn't qualify as making health services accessible," Louisa said.

Louisa then mentioned that Yaniv often referred his own "complex patients" to her – proof, in her eyes, that his clinic wasn't capable of providing good secondary care. In her view, Yaniv was doing good humanitarian work, and his methods were not so different from AHE's in the sense that both clinics relied primarily on volunteers and good-will. But his main mistake, she implied, was in being proud of this small clinic, instead of critiquing the cynical grounds for its existence (i.e., the exclusion of asylum seekers from full state-sponsored medical coverage).

Asked about his clinic's broader role within the Ministry of Health, Yaniv had made it clear that his interests were not the same as AHE's. He said simply, "I don't deal with politics. It's a community clinic." He then expressed anger, however, that AHE was not collaborating with him. He had been sending AHE insulin for months, he said to my surprise, and complained that they did not reciprocate with other supplies, or even notify him when they sent patients back his way. How did AHE expect the Ministry of Health to make its policies more inclusive when they refused to talk to the Ministry? he asked. Rebecca, AHE's clinic manager, was outraged to hear this. "His first mistake is thinking this should be a partnership, or a two-way give and take," she exclaimed later. "*We should* be referring people to him! He's part of the government!"

When I pressed Yaniv on the clinic's ability to treat life-threatening illnesses, he deflected the question twice. Then, he suddenly said, "*We* [the clinic] have doctors in Ashdod," referring to a coastal city south of Jaffa. "Why doesn't AHE have doctors in other cities? Why only in Jaffa?" he continued with a provocative hint of mock self-righteousness. We do, I responded, caught off-guard. "But not primary care doctors; only specialists, right?" Yaniv

persisted. “What if patients live in another city and don’t have 15 shekels for the bus to get to Jaffa?”

Yaniv had a compelling point: namely, the same criticisms that AHE aid workers had lobbied at him regarding his clinic’s limited capacity, he claimed, could be turned back at them. His clinic, they had argued, was intended to be a stand-alone that would not hook up to the governmental system, thereby minimizing cost while keeping crises down. It thereby perpetuated, rather than alleviating, asylum seekers’ exclusion. Yet AHE, Yaniv pointed out, had its own self-imposed limits: it habitually turned some of its patients away, and failed to station regular general practitioners in other cities, whereas his own clinic did. Their limits, he insisted, were as intentional as his own.

Yaniv’s point about herding patients like cattle shed light upon yet another important dimension of aid work at AHE. Namely, these crowds, like the misplaced medical files, were not simply signs of failure or pawns in a broader advocacy game, I suggest. Rather, they were also common aesthetic tropes of humanitarian medicine that some AHE aid workers – although certainly not all – had come to internalize. This aesthetic dimension added additional layers of complexity to the apparent chaos and habitual failures at the clinic. Such failures were not simply a byproduct of mandate reconciliation, but also reflected attachments, conscious or otherwise, to a particular performance of “bush medicine.” Chaotic gatekeeping and misplaced files tended to reinforce such performances.

As Annalise Riles (2000) and Matthew Hull (2012) argue, documents possess an important aesthetic dimension: their significance is not simply in the information they convey but also in the appearance of order. Ebrahim (2003), for example, has noted with respect to NGOs in rural western India that the very act of collecting documents and reports carries an

important aesthetic value, which “lies in the signals sent (to funders for example) by gathering [information], and not necessarily in using it in decision processes” (p. 96). The gilded appearance of the governmental clinic supported a similar argument, I suggest; to NGO actors or those affiliated with them, it did not seem like a place where serious life-saving could happen. “It’s a charade,” claimed the co-founder of a food NGO unaffiliated with AHE. He visited the governmental clinic shortly after I did.

[It’s] meant to give the impression that the government is taking care of the refugees. I’ve seen it, there’s nothing there. They should be ashamed. Limited opening hours, and you make an appointment for another day. It’s idiotic. AHE is how it ought to be... [AHE] just looks like a clinic where work is being done. They do serious work, I’ve been there. Forty people in their tiny waiting room at any given moment. This is what treatment looks like. In [the government clinic] there weren’t a lot of people.

His impression was technically inaccurate: there was much more than “nothing” going on in the governmental clinic. Besides, AHE itself had limited opening hours. Yet it was precisely this impression, and its implication that messy and crowded aid equaled “real” humanitarian work, that affirmed the significance of performing the right humanitarian visual aesthetic (Stirrat, 2000, 2006).

Organizations dealing regularly with donors know how important it was not only to give aid, but also to fit particular publics’ expectations for what aid should look like (Stirrat, 2006). Nofar, one of AHE’s administrative assistants and the organization’s longest-lasting paid employee, understood this point well. Indeed, she defended AHE’s chaotic activities primarily in aesthetic terms. “I know we are messy and crazy, and I’m ashamed of it sometimes,” she said, and elaborated:

We lack money and staff and resources, but this is how it needs to be. I don’t mind donors coming to visit and seeing this. I would be *more* ashamed if we had ritzy chairs and a high-heeled secretary walking like this [imitating dainty gait]. I’d be ashamed to

show it to donors. Because then I would know we don't need money. But as things are, we do need money and it shows.

Nofar's argument, I suggest, should not be taken to mean that the chaos at AHE's doorway was merely a calculated move to look "ragged enough" to earn donors' approval and money. Indeed, while demonstrating some scarcity was necessary to make a case for more funds, looking too ragged could easily lose donors. Raggedness mixed with proven competence, on the other hand, exemplified perhaps by Sandra's "rogue" sidewalk chemotherapy, had an undeniable charm among some donors who romanticized frenetic motion and against-all-odds success. Indeed, this idealization of what Annalise Riles has called the "aesthetics of failure" (2001, p. 19) permits some measure of treatment failures to persist at AHE, simultaneously mourned and celebrated as an undisputed aspect of the humanitarian repertoire.

VERGES OF CRISIS AND THIRD WORLD MEDICINE

In Peter Redfield's (2013) ethnography of Médecins Sans Frontières (MSF), the organization's missions in Uganda struggle to determine whether areas beset by relatively "mild" conflict still merit intervention. If they stay in the region, MSF staff wonder, what will be their role vis-à-vis local governments? And what quality of care should they aspire to provide? Such questions arise in all aid contexts, but crises that are neither sudden nor acute call particular attention to questions of long-lasting obligation: how long should NGOs should stay in regions with a simmering, low-grade crisis that regional powers are unable or unwilling to alleviate? This question betrays aid organizations' discomfort, Redfield (2013) argues, with needs that lie outside an archetypal emergency.

Craig Calhoun (2010) has explained such discomfort in terms of an emergency imaginary, which sees crisis as a state of exception from a normal order, and calls for an immediate response to that crisis. According to Calhoun, emergency imaginaries are tempting

ways of seeing: humanitarian organizations tend to see aid settings as sites of acute emergency, ignoring slower and more insidious forms of need. For this reason, they are more likely to privilege immediate action at the expense of long-term work. Bronwyn Leebaw (2007), a political scientist writing about humanitarianism, has also noted something similar in the pattern of daily aid work, which she argues often “draws on the imagery and emotion of rescue in ways that elide questions about the political context of violence and implications of intervention” (p. 229). The imagery of rescue, Leebaw continues, implies “that there is one proper course of action, and that the contours of this course are quite plain, just as it is plain to see what must be done when a fire is raging” (p. 229). Concerns with long-term sustainability of aid, in particular, are not the emergency imaginary’s strong suit.

Aid workers at AHE, I argue, often fell into this imaginary, unwittingly reading the needs in front of them as emergencies, and discounting those that did not seem to them like emergencies. In the previous chapter, for example, I noted that life-threatening conditions elicited more sympathy among volunteers than merely chronic ones. Yet more subtle manifestations of the emergency imaginary arose often throughout my fieldwork, many of them pertaining to notions of ambiguous need. One day, for example, an ailing asylum seeker was requested by two young volunteer receptionists to pay the customary 30 shekels (about \$8.50 USD) to open a new medical file.²² He obligingly opened his wallet to pull out the money, and as he did so, the volunteers noticed what looked like a wad of two-hundred hundred shekel bills tucked inside.

²² This was the only point at which AHE ever voluntarily charged patients money for primary care. These 30-shekel payments were typically pooled together and then used to fund emergency patients’ taxi trips to the hospital. Such payments proved particularly useful, moreover, in promoting patient involvement and compliance with treatment. Apart from these 30 shekels, however, AHE could scarcely cover expensive treatments, and so other costs often did fall to patients themselves.

The money, likely amounting to a few hundred American dollars, was a shocking sight to these two young volunteers. Speculating in hushed tones about its origin, they berated the man behind his back in Hebrew for taking up a spot at an understaffed free clinic, instead of paying the full price of several hundred shekels at a private clinic. As Lisa Malkki (1998, p. 382) has noted, “a rich refugee was a contradiction in terms:” actual or perceived wealth obscured conditions of exile and political vulnerability.

In her ethnography of Botswana’s AIDS orphans, Bianca Dahl (2014) illustrates how aid workers and villagers came to associate young orphans with thinness. Those who were not thin, and thus did not conform to others’ expectations of their physical vulnerability and material deprivation, often elicited anger in those who assumed they were receiving preferential treatment by NGOs. Thus, Dahl notes, “fat and skinny bodies provide[d] conceptual fodder for villagers, aid workers, and orphans alike to negotiate [...] changing forms of resource provision” (p. 628).

AHE aid workers reacted much the same way to the wad of bills in the man’s wallet. Their eyes moving unconsciously from the wallet to the man’s comfortable gait and relaxed body language, they wondered how he could truly be in such urgent need, and unable to help himself, that he deserved free medical care. Uncomfortable at their own association of refugees with abject poverty, they nevertheless found this man’s several hundred shekels disorienting. Unlike many of the clinic’s patients, a 20 shekel bus ride from Jerusalem would not faze this man, nor would a 15 shekel falafel sandwich from the shop across the street. Refugee or not, he seemed to have the kind of disposable cash that many an Israeli citizen would envy. From one perspective, giving him a ticket at the expense of impoverished patients seemed absurd.

It was unclear, they admitted later, where the money had come from. Perhaps he had a stable income or a loan; or maybe it was a *chik-chak* (one day only) construction job’s weekly

spoils, with which he needed to support himself and others for several weeks. And if he did eventually need complex medical treatment, there was little question that several hundred shekels would not go far. But once seen, this wad of cash, which they glimpsed only by accident, elicited a suspicion that they could not shake; the very act of walking into AHE's clinic with such a thick wallet seemed culled from the same genre of deception that other patients habitually practiced – selling tickets, lying about their names, and hoarding the sign-up list.

The ethical dilemma this man posed was not as rare as it seemed: aid recipients often subvert their benefactors' naïve expectations about their needs. Laura Wagner (2015), for example, writes of displaced persons in post-earthquake Haiti who sold the tents that aid organizations had given them. Instead of using them as living quarters, they preferred to bunk in other tents and sell theirs. Their actions elicited in aid workers anger and confusion about what counted as profiteering and what as legitimate need. The latter struggled to grasp that their recipients might want not simply tents to sleep in, but also a respectable amount of money to live on, and that they had few qualms about exchanging one commodity for another.

For locals, Wanger (2015) notes, the tents were easy to strip of their humanitarian meaning; meanwhile, aid workers, for whom the tents were a symbol of caring and life-saving, considered selling them blasphemous. In such instances, there was little of the comforting moral clarity that aid workers associated with emergency (Calhoun, 2010; Redfield, 2005, 2010) to guide their actions, and they were left with complex questions: did they have the right to dictate precisely what was done with the goods they disbursed? And did recipients' hustling, or the extra cash it provided, make them less deserving of humanitarian assistance? AHE's young volunteers struggled with a similar ambiguity: should they still intervene on behalf of this

seemingly “rich” (or at least, economically better-off than most) patient even if it seemed as though he could easily afford private care elsewhere?

As Susann Huschke (2014) observes, doctors treating undocumented migrants in Germany expected their patients to perform a particular form of helplessness. One volunteer physician, for example, disapproved of a Mexican migrant who arrived at her office simply to ask for a second opinion regarding a matter she had already consulted her Mexican gynecologist about. This was “not a reason” to use a free clinic, said the doctor indignantly, discomfited that her young patient was so “well connected [and] well-informed” (p. 355). Other doctors were disturbed by the prevalence of mobile phones among their patients. Seeing these as markers of financial stability, Huschke writes, they did not understand that a mobile phone “simply constitute[d] a necessity for people who [made] a living by cleaning people’s homes, babysitting, [or] helping out in restaurants” and who needed to be reached by their employers (2014, p. 355-6).

Louisa herself had painstakingly learned to avoid making automatic associations between refugees and poverty. Yet painstakingly navigating the terrain of associations in the name of treating patients with respect could lead to other unintentional forms of condescension. The concept of privacy, for example, serves as a useful case study in the difficulty of avoiding paternalism in humanitarian contexts. Meirav, a 40-something primary care physician and veteran volunteer, once told me she was irritated to hear complaints about patients’ ostensible loss of privacy at AHE’s clinic. Her colleagues, I knew, habitually berated their peers for letting patients translate sensitive bodily complaints for each other, or for walking into treatment rooms without knocking.

Yes, Meirav acknowledged, conditions at AHE were cramped and patients were often used as translators for other patients. But loss of privacy, she insisted, should not be equated with poor aid delivery. She herself had worked in Africa, a widely respected rite of passage for aid workers. In Malawi, she said matter-of-factly, people had different notions of time: they often arrived at her clinic three hours early for no apparent reason. Punctuality and privacy, she insisted, were luxuries they had never known:

It's Western, this concept of privacy. Patients themselves don't care if others can hear them. I've worked in Africa, and if we apply [our privacy standards] to them, then it's the same degree of colonialism as those who ignore their wishes altogether... It does not bother them to talk about their ailments in front of others. It does bother them to discuss rape or to strip, but not other things. In hospitals in Africa, they sleep in dozens of beds per room. You really think there's lots of privacy there? Here, we are shocked by their sleeping in cramped beds in 1-bedroom apartments in south Tel Aviv, but in Africa they do the same. In Malawi, I'd open my clinic at 7 a.m., but it didn't matter, they'd still show up at 4 a.m.

Meirav's argument about privacy and concepts of time was motivated by genuine concern about what she perceived as her colleagues' paternalistic attitude. Their mission, she implied, was to rescue patients from trivial first-world indecencies that paled in comparison with their genuine medical concerns; in her view, obsessions with privacy were a waste of energy that sought to restore patients' dignity by objectifying and coddling them. At the same time, Meirav's own sweeping claims drew the same kind of criticism – that she patronized her patients by assuming that like infants, they had only simple needs and crude sensibilities, and were not discomfited by exposures that would embarrass “Western” patients.

As Cooper and Packard (1997) have argued, critics of aid are often as prone to reifying differences between traditional and modern, as are staunch believers in the backwardness of non-moderns. Daily practice at AHE exemplified this well. Accusations of paternalism often flew in numerous directions, targeting both those who were deemed too protective and those deemed not

protective enough. Neither Meirav nor her privacy-craving peers, in other words, could achieve an unmediated gaze, nor could they traverse the gulf that existed between themselves and patients. Even close regular contact with patients had failed to achieve the coveted understanding. As Michael Barnett (2010) argues, “the discourse of humanitarianism contains elements of both emancipation and domination [...] such contradictory impulses,” he continues, “are best understood through the concept of paternalism” (p. 105).

Deliberations about privacy are relevant to the discussion of emergency and crisis because they pertain to what aid workers considered to be “normal” for their patients. While Meirav and some of her peers were not overly concerned about privacy, other needs that presented some ambiguity were often interpreted as urgent ones. One day, for example, a young man arrived at the AHE clinic with a badly injured leg, leaning on a friend for support. Seeing that he could not put weight on the leg, a volunteer handed him a pair of crutches. The physician on duty soon said he needed to go to hospital immediately, but Louisa and Rebecca refused to part with the clinic’s only pair of crutches, and so the young man gave them back.

Two young clerical volunteers protested. Local hospitals did not give out crutches for free, they pointed out: how would he manage without them once discharged? But Louisa was impassive. The argument soon escalated into shouting, with one of the volunteers running outside and thrusting her body half inside the taxi to prevent it from leaving, while Louisa irritably rapped on the hood of the car to motion the driver to go.

Uri, hearing about the incident the next day, burst into laughter. Some volunteers had lost their minds, he said. “Look, how did he arrive in Israel? If he didn’t fly here from West Africa, then he also didn’t get here by telekinesis. If he was resilient enough to get here, then he

can get to and from the hospital by himself.” Because they don’t speak our language and look down on their luck, he added, we don’t understand that they’re a lot more resilient than we think.

Yes, crutches would have been a good idea, Uri acknowledged, and yes, AHE could easily bought a few more crutches after giving him their only pair. But this, he insisted, was not the point. AHE could not and should not aim to give first-world care. Instead, he claimed,

[t]he important thing here is whether these people are getting “good enough” care. And the answer is some are and some aren’t. But according to which world of knowledge do people decide what kind of care to give, what AHE’s mandate is? Notice, for example, that even the doctors who volunteer with us don’t necessarily understand AHE’s scope and mandate. For example, some volunteer doctors ask Louisa why we don’t follow up with patients going to the ER. She clearly doesn’t understand our limitations, or our scope.

As Uri understood well, AHE’s scope and mandate were not simple matters to understand or even agree upon. They were, rather, an ever-moving target, as was the term “good enough care.” As Adí pointed out a few weeks later, “One of the biggest ethical questions we are battling here is, do these people deserve first-world treatment?” She continued:

Should we even aspire to give first-world treatment to refugees who barely have a stable place to live, and for whom a lot of these tests would be meaningless? Sure, this [*pointing at the clinic’s waiting room*] is bad. But is it not infinitely better than what they would have otherwise received? A lot of first-world medicine is defensive and litigious, anyway. Would that be necessary here? Of course not.

Such thinking, Adí acknowledged, might strike her colleagues as taboo, but it needed to be said, she insisted. At first glance, her statement may seem simply as a sober reminder of the litigiousness and excessive procedures of “first-world medicine,” which she implied were medically unnecessary and unlikely to be missed by asylum seekers. However, what about treatments in the “first-world medicine” repertoire that were genuinely life-saving and not simply “litigious”? Were these something that asylum seekers did need and deserve, and that AHE should aspire to provide? Or should asylum seekers who “barely have a stable place to live” be

content with less, or namely, with the “infinitely better” care that AHE currently provided, relative to what they would have received back home? In this manner, Adi’s well-meaning statement nevertheless appeared to collapse several uneasy rationalizations into one.

“Humanitarian practitioners,” writes Carna Brkovic (2014), however much they may desire to, “cannot treat lives as equal. Instead, they have to differentiate lives through intertwined influence of nationality, geopolitics, and compassion” (p. 8).

ON QUOTAS AND OTHER TABOOS

As I have shown so far, Activists for Health Equality’s aid workers struggled to decide what kind of care to give their patients, and how many to admit each night. Efforts to juggle aid and advocacy resulted in uneven aid practices: some aid workers panicked at the sight of a patient without crutches, while their peers engaged in an opposite kind of moralizing, defending the ongoing chaos in the waiting room as being only what one should expect from a small humanitarian clinic, and deflecting further responsibility to the Israeli government.

Aesthetic attachments to a particular performance of aid blended with political arguments about governmental exclusion to perpetuate AHE’s overall organizational ambivalence, generating a tapestry of uneven aid practices that perplexed newcomers and veterans alike. The reluctance of the staff to decide whether to put one more medical volunteer outside the door suggested that there was more to the ongoing problems than simply scarce resources or a high turnover of volunteers. It is clear, rather, that more complex organizational forces were at play: the vision of a rogue humanitarian underdog, and its attendant connotations of benevolence and rescue, served as powerful motivating factors for aid workers, even if not always recognized. These, in turn, paradoxically contributed to organizational inertia, which manifested itself in a

resistance to establish clear quotas on how many patients, and which conditions, would and would not be treated.

AHE's ongoing moratorium on explicit policymaking did not go unnoticed by volunteers. Eyal, who had fondly referred to his gatekeeping job as a "war," complained about the many AHE meetings he had attended that were meant to establish protocols but yielded few decisions. "There are so many unnecessary referrals, either because the tests aren't available or are too expensive, or they are not truly necessary, like vitamins, which are a luxury," he said. "And then the people in referrals sit and try to figure out what the triage people had meant," he smiled wearily. "So we *have* tried to establish protocols, yes, and there have been plenty of good ideas tossed around. But as usual, nothing has been done. And there was supposed to be a summary sent out of the meeting [on this issue], but it hasn't been."

One important policy stalemate concerned whether AHE should fund standard pregnancy screenings for healthy Eritrean women. In 2011 and 2012, the number of pregnant women showing up at the clinic rose dramatically. Their smiling faces and brightly-garbed round abdomens took by surprise practitioners who had been expecting to help sickly patients, not healthy ones. AHE had been funding these women's pregnancy screenings, but only a small trickle of patients had fallen under this category so far. Now, there were dozens each month.

Some aid workers proposed that even though these women were healthy, they still belonged to a politically vulnerable and largely impoverished population, and deserved to be funded. Uri vehemently disagreed, arguing that AHE's scarce budget should be spent on other tests. "A pregnancy not from rape is a choice," he said emphatically over lunch with me and Adí. "Two Eritreans who decide to have a baby, they should take responsibility and pay the few hundred shekels for prenatal tests. Pregnancy is not a disease, it's not our business. Otherwise,

we are not giving them the responsibility that should be theirs.” Dozens of new women, he pointed out, were now coming every month, and more would soon come. How long could AHE keep affording their tests, and what other patients would suffer as a result?

Li’or, one of the medical residents, disagreed with this view. “If [citizens] get it, then they should, too,” he said. “Especially since they wouldn’t be able to deal with the consequences of Down Syndrome and other conditions.” In terms of cost, he pointed out, no hospital would ever refuse a severely ill or premature baby, and one day in a premature unit cost thousands of shekels – which the government would ultimately have to pay. Screenings were cheaper, he added, seeming to forget for a moment that it was AHE paying, not the government.

After a moment, Li’or added that since he thought the right to bear children was a basic human right, then the right to make sure a child was healthy surely fell under that right. Schooled in public health-oriented, prevention-over-cure paradigms in medical school, it only seemed natural to him to move from notions of cure to notions of prevention, and from the limited boundaries of emergency to broader conceptions of care. For Uri, however, such a shift would push AHE too far from the rubric of emergency into a broad public health mandate that he believed the organization could not afford to adopt – whether politically or economically.

After several months and many meetings, still no decision was made regarding whether to continue funding pregnancy screenings. Meanwhile, most women who arrived at the clinic continued to be funded, Uri said; but whether each woman specifically got funded likely depended, he added sarcastically, on how compassionate any given volunteer on duty was. Whenever he cornered Rebecca on this issue, he told me, she stuttered and evaded him. For months, she failed to bring this issue to her superiors or make any decisions on her own as

manager. As in many other AHE spheres, there was action without policy,²³ AHE staff neither relying on past policy nor future policy-writing, but rather muddling through. “Nothing got decided, we’re still funding those tests... as long as the clinic is an outgrowth of the organization and isn’t independent, it’s doomed to reproduce this kind of thing. People jump from place to place, don’t last long, and there’s no money to bring in a professional.”

AHE’s relationship with the Ministry of Health, Uri argued, showed precisely this kind of schizophrenic indecision. Unwittingly supporting the complaints of Yaniv, the governmental refugee clinic’s coordinator, Uri argued that AHE’s obstinate refusal to collaborate with that clinic came at the expense of patients. Contradicting AHE’s majority opinion, Uri also insisted that government clinic was capable of more than most of his peers assumed:

How and whether to transfer some of our own responsibilities to the government’s refugee clinic is an issue we’ve been stalling [since 2008]. For years, we’ve scorned them and ignored them. But ‘lo and behold, suddenly we find out that they’re doing good work at their puny little clinic, and that refugees have learned how to play us against them to suit their own needs. I say that if transferring responsibility to the state, which we have always wanted to do, means cooperating with this reviled government clinic, then so be it. We must sell out to win the war. But the problem is, we can’t even get to this level of discussion, since nothing here gets discussed or decided transparently, because this organization needs to stay at a crossroads between human rights and humanitarianism. The human rights-humanitarianism conflict is the key to its identity. To get serious about this problem, we really need to sit down with the government clinic, have a work meeting with them, and decide what to transfer to them and what not. Maybe we can keep the complex patients and they can take over simple or routine conditions. We also need to decide on some professional medical standards for sharing information among the organizations. Now, I understand that every organization, not only ours, has this schizophrenia and competing interests. But there was a steering committee meeting that decided we would cooperate... So why hasn’t this happened?

²³ AHE had an ethics committee and steering committee, staffed mainly by board members. Despite access to numerous board members and meeting minutes, however, it rarely became clear how decisions were made regarding what conditions to treat and not treat. Many debates about pregnancy and other conditions lingered for months or longer. I spoke with numerous volunteers, employees and board members who had attended ethics and steering committee meetings, and it often appeared as though they, too, were perplexed and unsure about which, if any, decisions were taken afterwards.

Walking back to the clinic an hour later, Uri, now in a reflective mood, seemed to answer his own question. “We can’t set explicit humanitarian goals,” he said, “because then we’d need to shut down altogether, since some patients would invariably fall short of ‘good-enough’ care according to our new mandate. The purposes of our organization change depending on our needs and circumstances.” A deep aversion to quotas and limits, in other words, was built into the very fabric of the organization; uncertainty had become a zone of comfort.

The same aversion to quotas characterized AHE’s political mandate. While AHE formally restricted its advocacy to matters of health, it also supported other NGOs in their protests against the deportation of asylum seekers. As a result, the organization was occasionally drawn into acrimonious public debates of who was a refugee and who was an economic migrant. Like peer NGOs, many AHE workers realized that not all of their patients had fled individual persecution back home in ways that would qualify them as refugees according to the 1951 UN convention. Many, instead, were driven by less exotic reasons, such as poverty and indiscriminate forms of violence. And those who did suffer individual persecution, they knew, could rarely provide documentary evidence of it; militias, for example, rarely provided death certificates on command.

During staff meetings, paid and unpaid AHE workers directed their anger at the 1951 convention, describing it as a hypocritical, conservative legal tool designed to protect the global North’s borders in the guise of humanitarian inclusion (Cabot, 2013; Castles, 2003; Van Hear, 2011). Between forced and economic migration, they realized, lay not a chasm but an ambiguous landscape of ill-defined misery. Yet there was no good way for them to voice such critiques in public, or to argue for broader notions of deserving. They felt their roles as aid workers constrained them to repeat simple messages about everyone being a convention refugee,

because it was the only narrative that carried any or legitimacy or weight, however small, in the Israeli public sphere. Begging for compassion for economic migrants, many felt, would not be a prudent in a society whose xenophobic sentiments currently ran high.

The discourse on asylum seekers in Israel was polarized. Center-right politicians often claimed that asylum seekers were in reality almost all economic migrants. NGOs, meanwhile, had little choice but to counter that they were all refugees. “The NGOS don’t want to talk about quotas,” Abigail, AHE’s outreach director, said, “because then they’re setting a limit and admitting some won’t get in.” As Avi, one of the clinic’s co-founders, later put it, such an admission would “hurt the universality,” and for that reason, became taboo among different NGOs. Tom, AHE’s executive director, appeared to concur with Avi’s and Abigail’s analyses. During a staff meeting in March 2012, he said,

Suppose the government tells us, ‘OK, aid organizations, you win, we’ll [the government] take in 50,000 refugees.’ And we agree. And then comes the 50,001st one. What do we then do as an organization? Do we protest? Do we run a campaign to let more in? Do we appeal to international figures on how many asylum seekers other countries are letting in? What do we do?

Avi understood this dilemma well. But, he argued, it was a tactical mistake not to speak publicly of quotas. “The government’s strategy is not to let anyone in,” he said, “because they don’t want a million more people to come. So we’re locked in a stalemate: they want none and we ask for it all... what would break the government’s strategy is to give it a number.” Fifty thousand, he admitted, was probably too low, but aid organizations could easily say something like, “we’ll take in 100,000 refugees, but a country of 7 million cannot realistically take any more.”

Quotas and aid limits, Avi concluded, interfered with his peers’ aspirations to unconditional aid. As Barnett (2010) observes, “humanitarianism radiates a purity of motives

and an ethics of care” (p. 11). Such purity held important value for aid workers. Louisa, for example, had dismissed Yaniv’s government-sponsored clinic as “very humanitarian,” her tone brimming with disapproval to remind me that humanitarian aid habitually distracted from or precluded long-term solutions to political inequality. Yet as this chapter has shown, her words belied AHE’s own attachment to these imaginaries; reforms that limited them, like patient quotas and bureaucratization, for example, were not so much rejected as deflected or avoided at AHE.

In the humanitarian sphere, aid is often discussed as a place apart, often connoting religious transcendence. As aid scholar Michael Barnett argues, “there is of necessity a constant imperative [among humanitarian workers] to sanctify humanitarian action, to elevate humanitarianism from the everyday... to separate the moral obligation to humanity from the everyday responsibilities of life.” (2012, p. 26). It is tantamount, suggest Barnett and Bornstein, to “shifting the sacred from God to humanity” (2011, p. 25). Hard limits and policies on aid, meanwhile, threatened this process.

CONCLUSION: EXPECTATIONS OF ORDER

In an article provocatively titled “The Chaos of Humanitarian Aid”, anthropologist Elizabeth Dunn (2012) tells a grim story of humanitarian operations in 2008 war-beset Georgia. Dozens of international NGOs, she recounts, were flying in and out of South Ossetia, poaching local NGO staff and prioritizing short-term interventions that photographed well over longer-term ones that did not. They brought locals water and tents, for example, even after the latter insisted they had enough of both. Internally displaced persons, Dunn argues, “thus became not the customers or beneficiaries of humanitarian aid but parts of the *means of production* for NGOs as they sought to meet the requirements of their clients, the donors” (p. 14, emphasis added).

In Dunn's account, humanitarian aid is a cynical project. Aid organizations give locals unnecessary but photogenic commodities, choreographing the encounter to satisfy their donors' expectations. Yet the main problem, Dunn argues, "was not that individual projects were poorly designed or inappropriate to the situation. It was that [...] the aid system remained *patchy and erratic*, and thus could not constitute a seamless social order that would produce existential security" (2012, p. 14, emphasis added). "Humanitarian epistemologies" in South Ossetia, she continues, were based not on a master plan but on rules of thumb and "on *satisficing*," or "making decisions that were 'good enough' rather than optimal... Bringing water when it wasn't needed was an example of this kind of satisficing – it looked good to donors and fulfilled the agency's mandate for emergency assistance" (p. 14).

Dunn's first observation that humanitarian agencies periodically exploit their beneficiaries for the sake of organizational survival is a long-standing rallying point for the skeptics' camp of the aid and development literature (Barnett & Weiss, 2008; Leal, 2007; Maren, 1997; Stirrat, 2000, 2006; Terry, 2002). However, her second argument about patchy and erratic aid is something else entirely. Indeed, calls for "seamless social order" sound more compatible with the believers' camp, with its attendant faith in the perfectibility of aid through rational, systematic action, than in the skeptic's camp, with which Dunn appears to resolutely identify (Hodzic, 2006; Mosse, 2004). Yet to what degree is seamless order necessary to carry aid out, and to what extent do aid workers seek it? What meanings, meanwhile, does disorder assume?

As this chapter and the one before it have illustrated, daily practice at AHE typically fell far short of seamless order. Aid workers grew accustomed to working in a perpetually reactive mode, responding quickly to new governmental restrictions, rising patient numbers, fluctuating

volunteer labor and uncertain *combinot*. Efforts to instill tighter control would in a sense have been moot, since only so much of the environment could be predicted.

Yet in another sense, I have argued, appearances of disorder belied more complex processes. The absence of medically trained volunteers at AHE's entrance, for example, could have been corrected, and clinic hours could have been expanded. The fact that this did not happen despite considerable discussion reflected not simply managerial gaps or negligent execution, I suggested, but also a deep organizational ambivalence regarding AHE's dual mandates. Many aid workers attempted to follow in Sandra's lead, or at least, idealized exemplars of tireless life-saving; meanwhile, others kept advocacy goals close to heart, worrying about the impacts that tireless aid could have on these.

As Oren and El'ad's dispute illustrated, this dualism was not whittled down to explicit compromises or a fragile middle ground consensus. Rather, it intermittently emerged in the form of debates about how many patients to treat and which conditions counted as healthy or not. It also manifested in seemingly arbitrary patient quotas and uneven aid practices whose quality and quantity seemed to fluctuate with the stamina and determination of individual aid workers.

Prioritizing *less* aid, however, was not simply the domain of AHE's human rights advocates. As I have argued, the workings of the organization often suggested a subtle attachment, conscious or otherwise, to an emergency imaginary (Calhoun, 2010) that tended to legitimize scenes of distress and on-the-brink, nearly-failed humanitarian performances. Such imaginaries carried with them important aesthetic expectations. As Nofar put it, a daintily-gaited secretary would not have suited AHE's scrappy humanitarian image, nor would the orderly appointments and nearly empty chairs in Yaniv's governmental clinic. The emergency imaginary, in other words, brought with it an aversion to "too good" aid work that might reduce

a full-blown crisis to a low-simmering need. This reduction, it was feared, would not only dull advocacy campaigns, but also resembled too much the slow, indifferent routines of healthcare bureaucracies, rather than the more compassion-driven rhythms of humanitarian assistance. Some measure of failure, then, was tolerated and even valued by aid workers as bolstering performances of scrappy, renegade aid delivery that donors were thought to appreciate.

As Peter Redfield (2013) notes in his ethnography of Médecins Sans Frontières (MSF), humanitarian organizations like to punctuate their histories with references to epochs of extreme suffering and heroism. In reality, however, most operate on the verge of crisis. “Instead of one drowning victim,” he writes, “an indistinct crowd struggles in the surf” (p. 228). Caring for an indistinct crowd with variegated needs, in turn, demands new responsibilities, such as medical care for a variety of conditions, rather than only emergency treatment. Such a mandate, which invokes the burden of statehood, is one that few aid organizations wish for, and few can actualize (Calhoun, 2010; Redfield, 2010).

Aid workers at AHE evinced a deep suspicion of bureaucratization as they spoke about their work. To them, the business-like rhythms of a governmental healthcare clinic engendered a clinical distance between giver and receiver that threatened to collapse the tropes of selfless compassion that most of them still cherished. Attachments to notions of universality, therefore, resisted even the most minute bureaucratic reforms at the clinic. For aid workers who insisted on treating as many people as they could, stating quotas and acknowledging limits would amount to an untenable capitulation of two different ideals: namely, bureaucratization implied both less aid and an indifferent, regimented approach to care that contradicted the humanitarian ethic they were struggling to emulate.

In this view, the prospect of living in a verge of crisis, instead of “real” crisis, presented an important threat to AHE’s self-image. Yet maintaining AHE’s image as a rogue life-saving entity was not done simply by categorically denying aid to patients so that crisis would persist – doing so would have been perceived as much too callous. Instead, I argue, various *inactions* at AHE created a state of moratorium that helped keep the impression of crisis going. As I have described, the clinic was not expanded; Helena and other gatekeepers like her were often left to make admission decisions on their own; and decisions about quotas and limits were deflected.

Newcomers and veterans alike often protested and questioned the necessity of these decisions, and I do not mean to suggest that they reflected a calculated or sinister effort to keep crisis going or keep people in a state of suffering. Rather, they likely were a product, in the main, of organizational indecision about which mandate to prioritize, as well as an aversion to explicit quotas that might bind AHE publicly to limits on life-saving. However, the appearance of chaos, I suggest, then went on to play a separate role of its own in legitimizing the status quo and helping to prolong it.

For example, an aid worker who became frustrated at the MRI patient being forgotten could comfort herself with the reminder that AHE’s resources were scarce, and that mistakes like this one had to happen from time to time. At the same time, she maintained a nagging suspicion that this scarcity was not objective or inevitable, but rather possibly reflected some difficult decisions – or more likely, indecisions – at the managerial level. To reduce any resulting dissonance she might then feel about being a party to possibly intentional aid-withholding, she could compare AHE’s chaotic rhythms to other aid settings. This comparison was comforting, because it showed that AHE was not alone in its failures, and indeed, that its workings often resembled what “real” aid tended to look like.

I witnessed this logic unfold many times: Nofar, AHE's administrator who spoke derisively of daintily-gaited secretaries as a counter-factual sign of AHE not needing funds; Li'or, who spoke in the previous chapter of the man with the abdominal tumor in Ethiopia about which nothing could be done; and the food NGO founder who scorned Yaniv's gleaming clinic, I suggest, all implicitly drew upon imagined humanitarian work *elsewhere* in order to legitimate AHE's own failings and comment on the challenges of humanitarianism at large. In other words, while the ongoing chaos at the clinic may have been largely the product of the AHE's vacillation among aid and advocacy, deep-seated aesthetic assumptions about "real" aid being unavoidably chaotic, I argue, helped to legitimate this chaos thus prolong it. Chaos thus became, to an extent, normalized.

If this argument seems somewhat overstated, then I would emphasize that I ascribe no malicious intent to aid workers themselves. Rather, Jasanoff's (2004) account of co-production, I suggest, might be a more fitting idiom for what was going on at the clinic. Namely, a particular form of social order (chaos-laden aid work), and a particular way of seeing it (the emergency imaginary and aesthetic manifestations thereof) both co-constructed and reinforced each other. Yet for those witnessing the chaos at AHE's front door, I suggest, it would be difficult to see this, or to separate mandate reconciliation from emergency imaginaries as factors responsible for the prolongation of chaos. The chaos, rather, tended to take on a self-evident quality that obscured and muddled these factors.

Even though AHE is a small medical NGO in Israel with an explicit dual mandate of human rights and humanitarianism, I argue, its struggles are evocative of broader tensions between short-term and long-term goals in the humanitarian sphere. Namely, they raise larger questions regarding the extent of aid organizations' responsibilities relative to governments.

Citing Ilana Feldman (2009), Heath Cabot (2013) notes that “the temporary, ad-hoc nature of ‘crisis services’ puts into abeyance questions of governmental legitimacy and responsibility” (p. 75). In other words, are NGOs there, as Louisa put it with respect to AHE, merely to save those who cannot wait for governmental reform to take place, or to compensate indefinitely for governmental neglect (Abramowitz, 2015; Castañeda, 2011; Redfield, 2013)?

AHE’s “rogue medicine on the brink of collapse” image serves to reflect and reinforce AHE’s sense of helplessness in this context *and* its performance of helplessness, which presents AHE for the benefit of donors and its own aid workers as a valiant fighter just barely making it. This kind of self-idealization is not unique; as Cabot notes with respect to legal aid workers in Greece, “extensive discussions among workers about their limited resources and capabilities perpetuate an institutional ethos of lack and helplessness” (2013, p. 76). As I have suggested, this perpetuation has an element of intentionality that manifests in various aesthetic dimensions and temporalities of aid-giving. Finally, AHE’s limits on aid are not unique. Numerous aid organizations have a penchant for framing healthcare as a universal human right to which all humans are entitled; yet their own capacities are often limited by complex political entanglements and finite attention spans (Feldman, 2009).

Abigail, for her part, seemed to take a curious enjoyment in her colleagues’ indecision and vacillation among aid and advocacy. Instead of viewing such tensions as purely catastrophic for patients and for AHE, she suggested they were also healthy:

I’d say that first of all, this tension [between aid and advocacy] is healthy for our organization [...] because human rights organizations sometimes get too theoretical, too purist... I [also] think this organization should accommodate different individuals and viewpoints, [including] the most radical, the most humanitarian... if we can’t do that, we’ll lose a layer of discourse that it’s important for us to protect. I dread the day we become professionalized with all the boundaries and ‘impacts’ arranged in excel documents. It’s important but it’s also important to keep this fire. Without this fire there’s no point in all this work.

Tom, AHE's executive director, appeared to share some of Abigail's appreciation for these ongoing debates. He seemed a laid-back manager who lived comfortably with contradiction, and his staff often corroborated this view. He made little effort, he claimed, to control frontline practice or make it unitary and consistent, as he knew this was an impossible task. Some data *were* periodically collected regarding patients' conditions and treatments, but these were largely initiated mainly by visiting researchers using AHE as their case study in order to pursue political, epidemiological, or sociological studies. On the whole, Tom and his colleagues knew of but a fraction of the names that populated AHE's widespread volunteer networks. They seemed to make little effort to map them or formalize them, as these were constantly changing. Contextual demands and constant shifts in these networks, Tom added, would make any strict guidelines impossible to comply with. As Richard Lipsky (1980, p. 14) has written, "rules may be so voluminous and contradictory that they can only be enforced or invoked selectively." Tom seemed to intuitively share this view.

At this point, we may wonder how a larger humanitarian organization would have handled AHE's chaotic gatekeeping. I have emphasized how aid indeterminacy arises in everyday practice, and illustrated the constraints that necessitate improvisation and that allow for a certain tolerance of disorder. Yet even a relaxed manager like Tom was still very close to the front lines, and possessed a rich understanding of the challenges that aid workers faced. In contrast, how would a supervisor or donor in another country treat the contingencies and failures that arose daily at AHE?

Donors and their managerial expectations played relatively minor roles in the narratives I heard at AHE. I asked about them often, but typically received only laconic responses that, at most, dismissed donors' preoccupation with narrowly conceived "impacts" while intimating that

in reality, donors did not look very closely over aid workers' shoulders, despite their rhetoric to the contrary.

The disarray at the clinic, I knew, was not completely hidden from donors; as I showed in the previous chapter, Rebecca described it quite frankly in some of her donor reports. Yet as one AHE aid worker speculated, donors often seemed to care more about broader variables and quotas, which were relatively easy to meet, than about complex and reflexive narratives, even when it was in their interest to probe deeper into such narratives. Admittedly, donor reports at AHE did not contain merely numbers and sanitized, general descriptions. Some of them contained a few carefully worded references to organizational disarray, meant to connote archetypes of a rogue humanitarian responding tirelessly to emergencies popping up in every corner (Calhoun, 2010). Such descriptions, despite risking censure or concern by donors, could also lend a legitimizing burst of color to an otherwise dry read. Yet how do donors and aid managers far from the front lines actually respond to such reports? In the following chapter, I transition from the humanitarian trenches in Israel to a geographically dispersed, global humanitarian infrastructure in order to explore how supervisors, policy makers, or donors who are far from frontline aid practices exert, or seek to exert, a measure of monitoring and control over frontline humanitarian practice.

CHAPTER 3

REFORMING PARACHUTING PSYCHOLOGISTS

What kinds of information do aid donors and policy makers, particularly those removed from the frontlines, have access to with respect to the daily aid practices that frontline aid workers perform in disaster and war zones? (Scott, 1998). How is such information translated and communicated between frontline aid workers, consultants, managers, and donors in an era of rising humanitarian managerialism? (Ebrahim, 2003; Porter, 1995). So far, we have seen how aid workers cope with unpredictable resources and competing agendas in the front lines. In the following three chapters, I step back from the world of daily humanitarian aid delivery in order to consider how aid supervisors, donors and policymakers situated far from the frontlines seek to manage, oversee, and at times alter frontline practice. For example, how might aid actors obtain information about instances of frontline discretion and indeterminacy, of the kind that occurred daily at AHE? To what extent might they find objectionable (or tolerable) those frontline acts that habitually diverge from official directives, and for what reasons? And to what degree might aid actors attempt to closely govern frontline practices or, conversely, to permit aid practitioners a measure of discretionary power that takes into account the shifting of resources, actors, and agendas in daily practice?

Examining the interplay between both ends of the humanitarian spectrum – daily frontline work and policymaking – offers an important path to understanding how new visions of social order, improvement, and knowledge are created, negotiated, and at times resisted across a network of sites, actors, objects and practices that are quite widely dispersed, both geographically and in terms of institutional degrees of separation. This approach may then permit us to understand why aid practices so often diverge from the expectations and blueprints

of those who fund them (Mosse, 2005; Roe, 1991), as well as why such blueprints are frequently criticized as unable to do justice to the needs of populations living in conditions of poverty and violence (Barnett & Weiss, 2008; Feldman, 2009).

The actors involved in the aid and development sphere – and these may include donors, project managers, heads of mission, local and international staff, contractors of all kinds, and recipients – frequently disagree regarding the needs that most deserve attention and funding, the most apt terminology in which to capture and understand such needs, the best approaches with which to attend to them, and the most efficient ways to communicate about them across large distances. Examining not simply either frontline practices or policymaking efforts, but rather both, would therefore allow us to better understand how such disagreements emerge among actors, and how they both attempt to resolve them and to advance their own interests, whenever possible, in ways congruent with their own particular visions of doing good (with which other actors may disagree). To this end, I devote the remainder of this dissertation to exploring tensions between frontline practice and policy-making efforts in the field of humanitarian mental healthcare and psychosocial support. It is a relatively new and highly contested field of humanitarian practice that offers, for this very reason, an excellent site in which to examine processes of knowledge production and governance in the aid sphere.

While still within the medical spectrum and thus also invoking similar questions regarding whom to treat, and which lives and ailments are most and least valued, that we also have seen with AHE, humanitarian mental health interventions bring to light new questions regarding the meaning of mental well-being and the actual and imagined roles of Western psychotherapy and other mental health techniques in coping with the devastating effects of war and disaster. Since the 1980s, mental health practitioners have been increasingly visible in

conflict and disaster zones. Though largely associated with psychiatrists and clinical psychologists conducting primarily brief therapy stints with local populations (Fassin & Rechtman, 2009; Pupavac, 2001; Summerfield, 1999; Wessells, 2009), mental healthcare in humanitarian settings spans a wider spectrum: many of the field's practitioners have been social workers, art therapists, logisticians, teachers, and college-age volunteers assigned to broader "psychosocial" projects. In the eyes of critics, many of these aid workers are not career humanitarians, but rather practitioners based in the global north who venture on short-term aid missions abroad. As such, many are largely unschooled in the ethical and logistical ambiguities of the humanitarian sphere. They are seen as eager to "arrive in an emergency situation with certain skills and commitment but little or no fund-raising or geographic expertise" (Smillie and Minear, 32). Boasting a wide array of disciplinary backgrounds and typically initiating brief, short-term interventions that are separate from more institutionalized bodies and missions, many psychosocial responders have escaped the scrutiny of aid bodies, donors, and local governments, arousing suspicion regarding the efficacy and impact of their work upon disaster- and war-struck populations. This suspicion, coupled with the brief duration of many such interventions, has earned these aid workers the unflattering moniker "parachuting psychologists."

The parachuting psychologist is a stereotype and a metaphor, not an objective description. Practitioners active in the humanitarian mental health field are increasingly aware of it, and work hard to avoid such accusations themselves. Nevertheless, for critics, evidence of parachuting has remained overwhelming despite the growing reflexivity of some practitioners, raising widespread alarm about potential harm to local populations. The problem, critics have argued, is that parachuters frequently frame the ills of disaster and war in medical and psychotherapeutic terms; that they are quick to use a hodge-podge of Western psychotherapeutic

techniques to treat individuals for whom such methods might mean little (Kienzler, 2008; Littlewood, 1992; McHugh & Treisman, 2007); and that they carry out improvised interventions not grounded in any scientific evidence, reinforcing stereotypes of psychotherapeutic techniques as soft and unscientific (Kienzler, 2008).

Throughout the 1990s and early 2000s, such criticisms slowly permeated the top echelons of the humanitarian policymaking world. In 2007, after years of debate by policy makers, academics, and practitioners about the burgeoning humanitarian mental health specialization, the United Nations-led Inter-Agency Standing Committee (IASC), an international consortium of NGOs and UN bodies,²⁴ published a landmark document titled “Guidelines on Mental Health and Psychosocial Support in Emergency Settings.” Co-written by several dozen prominent mental health practitioners, researchers, and policy makers, this 181-page document represented the first major effort to contain, define, and govern this new field of knowledge and practice.

In this chapter, I address these ongoing efforts to reform humanitarian mental health, reading them as an important case study in how aid is monitored and governed. Often discussed in official parlance as “vertical” (i.e., non-collaborative), “vertical and clinical,” or simply short-term interventions, instances of parachuting have embodied two of the aid skeptics’ most important anxieties: that aid constitutes a hubris-laden imposition of Western technology upon non-Western knowledge systems, which it simultaneously erases or devalues; and that aid organizations force themselves upon unwilling locals without asking what they need (Ferguson, 1990; Hodzic, 2006; Mosse, 2004).

²⁴ According to its humanitarian mental health branch, “The Inter-Agency Standing Committee (IASC) was established in 1992 in response to General Assembly Resolution 46/182, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC is formed by the heads of a broad range of UN and non-UN humanitarian organisations.” (IASC, 2007, p. ii).

At the same time, curiously, parachuters have also embodied anxieties drawn from the so-called believers' repertoire: that parachuters are improvising interventions on the spot without grounding them in scientific evidence or rational action. I examine how these very different critiques have been posed from both ends of the skeptics-believers spectrum, and then proceed to examine efforts to reform the field. These reforms, I argue, have strained in two dramatically different directions: a sustainability-oriented reform (to satisfy the skeptics) and a rationalization-oriented reform (to satisfy the believers). Both efforts have mirrored existing trends in the broader humanitarian sphere, trends that I suggest are contradictory.

I begin by describing the parachuting archetype and a series of critical responses to it. What was it, for example, about the existing state of humanitarian mental healthcare that prompted the ire of policy makers and practitioners? What changes did they see as most necessary, and why? Next, I address the guidelines' so-called sustainability mandate and its evidence-oriented counterpart, examining the complex ways in which aid workers and policy makers have defined, understood, and contextualized both terms. These two agendas, I suggest, implicate different notions of accountability in the field of humanitarian mental health.

PARACHUTING PSYCHOLOGISTS

Until the 1980s, mental healthcare was not an independent field of humanitarian assistance. Rather, it was seen largely as something that would be taken care of indirectly through food aid, shelter, and community-restructuring efforts. Aid scholars tend to concur that beginning in the 1980s and 1990s, psychologists and psychiatrists began to join humanitarian missions principally to order to attend to mental suffering as a thing apart (Ager, 2012; de Vos, 2011; Fassin & Rechtman, 2009; Grove et al, 2006).

While I have not been able to find exhaustive historical accounts of humanitarian mental health as a discrete field, a widely cited *Lancet* article (Mollica et al., 2004) on mental health in emergencies marks the late 1980s Cambodian refugee crisis along the Thai-Cambodian border (nearly a decade after the Khmer-Rouge genocide) as the first time the international humanitarian relief community recognized a mental health crisis as a deserving its own focus of intervention. Meanwhile, Didier Fassin and Richard Rechtman (2009) trace the beginnings of humanitarian psychiatry, as they call it, to the Armenian earthquake of 1988, where they find evidence of mental health practitioners focusing specifically on psychological ills. While this transition is often noted as an important and beneficial development by humanitarian mental health practitioners, as it helped direct funds and scientific expertise to the topic of mental health in war and disaster zones, observers and scholars of the field tend to paint a more circumspect picture of disputed expertise and unregulated interventions.

According to Fassin and Rechtman (2009) and Mollica et al. (2004), humanitarian mental healthcare did not emerge as an established field of practice until the 1990s Balkans crisis. Michael Wessells (2009) endorses an even more recent institutionalization. Even in the late 1990s, he claims, mental health interventions were still being “relegated to the humanitarian ghetto and seen as things to be done after the ‘real’ humanitarian work of saving lives had been completed” (p. 842). For Wessells, the true consolidation of humanitarian mental health came several years later. “More than any other single event,” he writes, “the 2004 Asian tsunami brought home to people worldwide the enormity of the psychological needs that emergencies create.” (ibid.)

It might seem tempting, Didier Fassin and Richard Rechtman argue, to attribute the 1980s rise of humanitarian mental health to the 1980 inclusion of post-traumatic stress disorder

(PTSD) in the 3rd edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1980 (2009; see p. 179). However, they advise against such an interpretation. Until the late 1990s, they suggest, humanitarian psychiatrists thought of mental problems among humanitarian victims more in terms of broad suffering than in terms of trauma and PTSD. It was not until the Kosovo crisis that PTSD and trauma became household concepts with the power to see and name a new humanitarian need.²⁵ Even then, this was not a story of academic and clinical US psychologists expanding their sphere of influence to far-flung zones of war and disaster. It was, rather, the understandings of suffering within the trenches which expanded, leading to a gradual and sporadic growth of mental healthcare as a subfield of medical aid, which would later expand even further into "psychosocial" aid.

In the 1990s, trauma-focused psychotherapeutic methods grew in popularity.²⁶ At the same time, so did a small contingent of scholars and practitioners who critiqued them. Wessells (2009), himself a vocal critic, captures the archetype of a well-meaning but ignorant Western practitioner for whom every humanitarian victim is a fitting target for therapy. "In 1999 in Tirana, Albania," he writes, "where camps [were] filled with Kosovar survivors of Serb attacks, an American psychologist had set up a tent for counseling women survivors of rape" (p. 843). This psychologist did not realize, he notes, that "for a woman to have entered the tent would have identified her as a survivor of rape, which many families regard as a stain on family honor" (ibid). Far from a unique mistake, argues Wessells, this case in fact reflects a larger problem:

In emergency settings, one often encounters well-meaning U.S. psychologists²⁷ who have no experience in international emergencies, little understanding of the local culture or context, and no relationships with the agencies or people in the affected areas. Although

²⁵ See Young (1995) for a history of the PTSD category and Kienzler (2008) for an account of how PTSD migrated from military to civilian and then development spheres.

²⁶ No particular reason is given by Fassin and Rechtman (2009) for the growth of trauma-focused interventions, apart from the presence at well-funded NGOs of particular practitioners who deemed trauma important.

²⁷ Wessells foregrounds American psychologists, but parachuters, he knows, come from many countries.

the psychologists are nobly motivated by the feeling that “I just had to come and help,” this approach has been described as “disaster tourism” or “parachuting” rather than as professional humanitarian response.²⁸

Rather than indicting the entire field, Wessells frames his critique as a warning to the “good ones” to not stray into parachuting. Parachuters, in this view, are the few bad apples: Wessells upholds a notion of unimpeachable professionalism from which parachuters presumably fall short, thereby consciously placing the blame with individuals rather than with the discipline itself.

After reading Wessells’ critique, I was eager to hear more about the so-called parachuting psychologist from psychologists, psychiatrists, social workers, and art therapists who had volunteered in different aid settings. Many of my informants were eager to share stories of those they considered to be parachuters. One American psychologist suggested that most of these were Westerners who felt an urge to help after a disaster but have little or no experience with aid. “I think people have been seduced by the idea of being heroic,” he said, “coming in and saving lives under terrible conditions and being heroes.” Marcela, an Israeli psychologist who has worked with 2004 tsunami survivors in Sri Lanka, likewise attested to the messianic efforts of some of her colleagues. “In the minute something happens, there’s a huge excitement. Everyone really wants to be there. It’s the first reaction.” Unfortunately, she added, it also meant that ego and vanity played considerable roles in such interventions.

One of Marcela’s colleagues had seemed to jump at the chance to go to Sri Lanka after the tsunami. “He took a group of kids in Colombo,” she said, “not even ones from the south [*the area most affected by the tsunami.*] And he ran them through some kind of drama activity, one-time only. Right next to the water. And that’s it.” She shook her head in incredulity before

²⁸ P. 843.

continuing. “And based on this intervention, he’s gone on to give lectures! In every possible conference, with beautiful photos of dark-skinned children smiling.” Noting my glance at her own photos of her aid work with Sri Lankan children, she paused with embarrassment, saying, “Okay, so I also have many photos of the stuff I’ve done. It’s not me against his ego, since obviously I have a lot of that, too. But the story is,” she continued,

that he didn’t know what was culturally acceptable and what was not. Kids will play with anyone, in any language. But he, his ego brought him there. He shows it off now to everyone and everywhere. Almost every person who was [in Sri Lanka] is proud of the work that was done there. I am not proud. I was there. And I think it was a colossal waste of money. Colossal.

As Marcela decried, some aid workers were not in it for the “right reasons;” rather, some wanted primarily to build their careers on such interventions, despite the fact that they often spent little time with humanitarian victims and knew typically little about their culture and livelihoods. Her colleague was a good example of this phenomenon, she argued. Another psychiatrist who had worked in Sri Lanka told me of an online psychosocial message board discussion he had seen within days of the 2004 tsunami. A Canadian psychologist had posted a question asking, “Can anyone please give us a short handbook on Tamil culture, so we can read it on the plane while going out there?” Recounting this story, my informant made an obscene remark to suggest that he could not believe the degree of ignorance embedded in this psychologist’s question, and its underlying assumption that all one needed to know about Sri Lanka in order to treat its people could be learned on the plane ride over.

Barry, an American psychologist who had taught graduate-level psychotherapy courses at a university in Kosovo, spoke with disgust of the “republic of NGOs” (Schuller, 2013) that greeted him when he first arrived there in late 1990s, particularly the glut of people who styled themselves mental health practitioners:

There was no coordination. There were very few real psychologists, but many people with BAs in psychology or something like that, from the USA, from Japan, from everywhere, who arrived as experts... Before I went there, I was full of admiration for the international organizations. And then I saw that people don't understand what they're doing. Someone comes, makes an emotional contact with you, and then leaves, says goodbye. And then another, and then another. What does that do to your ability to bond with others? They came on average for 6 months to a year, and then left. When you come to a totally foreign place, with a culture very different from the mainstream European one, by the time you learn who's against who, you leave.

Barry described these scenes to me in a deadpan, and sometimes on the verge of tears of anger. Young foreigners from the global north with scant training in mental health had come to "heal" individuals whose culture they scarcely knew, he said, his voice shaking; yet they were being introduced as experts. Their missions, he insisted, were brief and meaningless, and they knew nothing about how to help people in Kosovo.

Notions of parachuting, and of ignorance masquerading as expertise, are not unique to humanitarian mental health. A recent UN review of the humanitarian response after the Haiti earthquake, for example, reported "a majority of inexperienced, small NGOs and humanitarian workers who lacked a professional approach to and knowledge of the situation, a limited understanding of the Haitian context, [and] insufficient communication with the local population" (Johnson, 2012, p. 104). This report excoriates water and sanitation professionals, protection cluster professionals, medical staff, and food aid providers alike. But while critiques of humanitarian mental health practitioners' "insufficient training [and] minimum standards" (Abramowitz and Kleinman, 2008, p. 220) may not be unique to mental health, some critiques *have* been specific to mental health. For example, critics have questioned the applicability of post-traumatic stress disorder to non-Western populations.

TRAUMA AND PTSD IN WAR AND DISASTER SETTINGS

Trauma and PTSD have by and large played a polarizing role in the humanitarian sphere. PTSD and trauma remain the currency of choice for many practitioners, but others counter that such terms have no rightful place in the humanitarian sphere. However, as the term “trauma” is itself interpretively flexible, we find that many practitioners endorse one understanding of trauma as an explanatory concept while denouncing other understandings of trauma. This flexibility makes it difficult to pinpoint what, exactly, critiques of trauma as a humanitarian concept are actually finding fault with.

Critics have not minced words, but their opposition to trauma has often become conflated with their critique of parachuting itself, even though numerous trauma-oriented interventions take place in long-term facilities that could hardly be described as parachuting interventions, while numerous parachuting interventions address social and economic concerns that have little to do with the notion of trauma. Such conflation is apparent in multiple critiques. According to Peter Ventevogel et al., for example, trauma-focused interventions have tarnished aid settings with a “toxic combination of cultural naiveté and [of] therapeutic arrogance” which “amount[s] to the imposition of western concepts of distress and disorder to populations with different ways of understanding human suffering” (2011, p. 200). Wessells (2009, p. 844) suggests that “parachuters cause harm [by] using aggressive methods that pick people open but then leave them vulnerable and without appropriate follow-up.” These writers, who consider themselves field insiders, frame their critiques in tones that suggest devout adherents desperate to reform an ailing ideology.

But perhaps the most outspoken critic of PTSD is Derek Summerfield, a South African-born psychiatrist based at London’s Institute of Psychiatry, who has written and lectured

extensively about humanitarian mental health. In a widely cited 1999 paper entitled “A critique of seven assumptions behind psychological trauma programmes in war-affected areas,” he lays out a detailed case against trauma-focused humanitarian interventions. In it, he argues that PTSD is “a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counseling are applicable. These concepts aggrandize the Western agencies and their ‘experts’ who from afar define the condition and bring the cure” (1999, p. 1449). Most humanitarian mental health practitioners, he argues, are proud bearers of Western hubris and ignorance who do not realize how insulting it is to frame political conflict in technical terms, thereby denying locals the right to define the terms of their own misery and hoped-for redemption. His argument might be considered a genre-specific version of broader critiques of aid from the skeptics’ camp (Hodzic, 2006).

In Western cultural settings, Summerfield (1999) argues, echoing similar arguments by Frank Furedi (2003), notions of trauma and PTSD are widespread. Several middle and upper class generations have been reared on such terms, and been pressured to speak about their internal pain in order to heal it. This “confessional” pressure, Summerfield continues, can have disastrous consequences when applied to non-Western victims of conflict or disaster. It may, for example, go against local cultural or religious norms to remain silent about deceased loved ones; or it may persuade victims that they are unable to cope by themselves and require external intervention. But more importantly, he argues, the confessional mode medicalizes and individualizes the effects of war by directing victims’ attention to psychotherapeutic solutions in place of ones like political organizing or community reconstruction.

Drawing from Allan Young’s (1995) widely read critical history of PTSD, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, Summerfield traces PTSD back to the

aftermath of the Vietnam War. PTSD advocates, he argues, were able to push the diagnostic category into the DSM by insisting “that men widely seen to have perpetuated atrocities were also victims, traumatized by role thrust upon them by the US military establishment” (p. 1450). Putting the matter in more cynical terms than Young himself appears to have intended, Summerfield claims that “PTSD offered Vietnam veterans legitimated victimhood, moral exculpation and a disability pension” (p. 1450).

For Summerfield, the use of PTSD in humanitarian settings has come with the assumption the mental illness is the same everywhere, and that treating it would only require the psychotherapeutic toolkit that psychologists and psychiatrists already stand ever ready to provide. Summerfield concedes that some forms of human distress, like “disturbed sleep, bad dreams or plaguing memories” may indeed reflect “facets of a universal human response to traumatic events” (p. 1454). But even if that is the case, he continues, “how many victims think [these commonalities] point to the need for projects aimed specifically at their psychology?” (p. 1454).

In the colonial era, Summerfield reminds the practitioners to whom his article seems to be addressed, “psychoanalytic concepts were used to describe the restiveness of those under the imperial yoke” (1999, p. 1458).²⁹ In some cases, he adds, “their emotional lives were viewed as essentially basic, having the shortlived sentimentality of a child but lacking the complexity which in the European mind could incubate depression or neurosis” (p. 1458). Present-day humanitarian mental health workers who assume their beneficiaries’ fragile mental state, he cautions, could similarly be engaging in the “unwitting perpetuation of the colonial status of the non-Western mind” (p. 1458).

²⁹ See Richard Keller’s *Colonial Madness* (2007) for a study of colonial psychiatrists in the Maghreb and their approach to mental pathology and illness in colonial subjects.

Summerfield's 1999 critique targets not merely parachuting psychologists or even PTSD, but the entire field of humanitarian mental health itself. Any mental health responses to war and disaster, he argues throughout his work, should generally be considered inappropriate. Even without PTSD, he writes, humanitarian mental health is still individual-focused, which he sees as a mistake; the true meanings of war and disaster are irreducibly social and political and thus require social and political redress. "There is no evidence that war-affected populations are seeking these imported approaches," he writes, "which appear to ignore their own traditions, meaning systems, and active priorities" (1999, p. 1449).

I read Summerfield's critique before going into the field and found it compelling. But once I had interviewed two dozen practitioners, his critique began to seem perplexing. He seemed to be attacking a very small portion of the field: few of my informants were doing the individual-focused psychodynamic therapy that Summerfield seemed to assume they were doing. Most, rather, were helping locals recruit teachers and build schools on the ruins of ones destroyed by an earthquake, or helping set up play spaces for children, or, if it felt appropriate, asking people to speak about their grief but without prodding them to say more than they wished. To those familiar with the diversity of frontline practice in humanitarian mental health in 2015, Summerfield's critiques of the late 1990s and early 2000s sound one-dimensional, targeting only those interventions that revolve around individual psychotherapy, rather than those that imagine psychosocial health more broadly as amenable to diverse economic and social interventions.

Summerfield himself seems increasingly aware of the diversity of the field, yet his more recent writings (2012) resolutely echo his earlier ones. He considers his critique an important one in a field where ignorance and ill-fitting interventions continue to thrive, even if they are not as narrowly psychotherapeutic as they used to be. He has made no secret of his provocative

intent, which has embroiled him in several public controversies. Fassin and Rechtman (2009), for example, describe a 2001 controversy that erupted in response to one of Summerfield's articles. In January of that year, he published an article in the *British Medical Journal* entitled "The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category." In it, he argued that "trauma has become the most insidious form of Western domination" (p. 27).

Critical responses to Summerfield's article were swift, but interestingly, the angriest ones came not from practitioners, but from self-identified PTSD sufferers (Fassin & Rechtman, 2009). They accused Summerfield of seeking to deny them a hard-won right to be recognized as suffering from an illness over which they had no control. Summerfield's own point that victims of conflict or disaster in other cultures might not desire such a diagnosis was largely ignored in the ensuing controversy.

Summerfield has not been alone in his critique. Vanessa Pupavac (2001, 2002), a UK-based international relations scholar, has likewise traced the growth of PTSD as a humanitarian category to what she considers to be the late 20th century dominance of trauma concepts and treatments in many aid practitioners' home countries (Furedi, 2003). Reared in cultures that presume the emotional vulnerability of individuals, Pupavac writes, many Western aid workers tend to presume that trauma rates are also rampant among disaster and war victims far away.

Several studies in the late 1990s and early 2000s did find PTSD symptoms in the majority of disaster victims, and they were subsequently cited to bolster the legitimacy of hundreds of trauma-focus aid programs (Mollica et al., 2004). But more recent studies have taken pains to denounce this position and to report new findings that clinical depression, anxiety,

or post-trauma were rare among war and disaster victims (IASC, 2007). Many of these shifts, however, came after Pupavac's articles were published.

Pupavac (2002) considers mental health interventions a form of therapeutic governance. Mental health interventions, she argues, adopt a "mechanistic, deterministic model of the human psyche" (p. 364), employing medicalizing language to describe what ails disaster and war victims, often at the expense of their own interpretations of what has happened to them. Like Summerfield, Pupavac sees mental health practitioners as downplaying historical and social interpretations of distress, thereby discouraging victims from seeking political redresses to the ill fortunes that have beset them.

Recalling the disability pensions of Vietnam veterans from Summerfield's 1999 account, Pupavac (2002) writes of Kosovar survivors of violence being coerced into admitting they were traumatized in order to qualify for economic assistance packages. The diagnosis itself, in other words, serves as an aid gatekeeper. Many beneficiaries, in turn, perceive other economic benefits they might gain from foreign NGOs as long as they have learned to fit their expectations and speak their language. Citing one NGO's proud reports of Kosovar locals' enthusiastic response to its interventions, Pupavac (2002) wryly points out that their receptivity might be explained by the fact that they were subsequently hired as guards and housekeeping staff for foreign aid workers.

Pupavac's work, like Summerfield's, paints humanitarian mental health with a broad brush. While hers and Summerfield's insistence on the continuing domination of trauma-focused interventions may be overstated, their arguments regarding the dominance of trauma in the humanitarian mental health sphere captured well the anxieties of many of my informants.

One prominent American mental health researcher and consultant, whom I shall call Robert, saw trauma as alive and well in the aid industry despite growing criticisms of its use:

I'm going to be crude now: it's easy to raise money for trauma. It's easy to explain to people what you're doing. All you have to do is share a couple of powerful photographs to tell the story of a woman whose husband was murdered before her very eyes. These are things that are horrible, and they are compelling on a human level. The problem is that they are so compelling that they really grab people's attention, I think, in excessive ways... In the [international humanitarian] agency I used to work for, people in the fundraising department used to come [into] my office and they'd say "you took trauma from us. Tell us why." Because they knew that that was their big breadwinner.

Barry, the American psychologist who taught at a university in Kosovo, agreed that trauma had become so deeply ingrained in the international discourse about Kosovo that local students who wanted to learn community restructuring techniques at the local university were often redirected to trauma courses. "Trauma is a natural state. There's no person who doesn't undergo trauma," he said, clearly perplexed at the international fixation with the term. "The correct treatment of trauma in Kosovo and any other war-ridden place," he said, "is economic, political empowerment," he added.

Barry had just come back from Pristina, where he was training Kosovar graduate students in advanced psychotherapy. He had been flying to Kosovo to teach his seminars and plan curricula nearly every month for over a decade. Since his first mission to Kosovo, he had seen foreign aid organizations prioritize trauma in any intervention that concerned Kosovo. In spite of locals' resistance to such framings, many years of interventions directed from above had created an entrenched inequality between givers and receivers, which could not be undone by verbal promises of "participatory" aid. He elaborated:

What happens many times is what's called a corrupt dance. The international organizations give locals a sense of "you don't know anything, [but] we do." And then the internationals ask the locals, "What do you want?" And the locals, instead of saying what they think should be done, since they've long since stopped thinking, since the

internationals have made them stop thinking... they try to guess what the internationals want to hear, and tell them that.

As my informants' accounts suggest, Summerfield's and Pupavac's critiques touch an important nerve in the field. Their work is a vital as a reminder of humanitarian aid's colonial ancestry and of colonial psychiatry, in particular, whose echoes in present-day aid they were eager to point out (Bullard, 2007; Fanon, 1967; Keller, 2007; Vaughan, 2007). Such echoes cropped up regularly in my interviews, as well. For example, Marcela, the educational psychologist who had worked in Sri Lanka, had also spent years training Nigerian counselors in drama and art therapy techniques. She sometimes flew to Nigeria for short sessions, but most of the time, she trained Nigerian counselors over Skype. When I asked her whether she taught psychoanalytic techniques in addition to art therapy, she said no:

With psychoanalysis, most of the process is hidden. And it necessitates a very high level of abstraction, by the patient also. People who are poor and who search all day frantically for a penny to feed their families, and also to not get killed in the process – they are still in survival mode. And I don't think they are cognitively open to the mystery plus abstraction of an analysis of their childhood. Because at the end of the day, what does the psychodynamic approach say? That your reality today is a result of the past you've repressed, right? But these people, their reality is not a result of the childhood they've repressed. It's a result of a crazy, corrupt regime, which is why they go to hospitals where there is no running water for eight years.

Marcela's description invites several interpretations. One could read her words as being deeply attuned to the injustices her beneficiaries endure at the hands of their regimes: few of them, she is intuiting, would in such circumstances approve of foreigners' self-indulgent psychoanalytic takes on their hardships, let alone the political and economic profit that they would reap from treating them in this way. On the other hand, her description also uncritically perpetuates racial assumptions that recall colonial accounts of the so-called mental simplicity of colonized minds and the ingrained violence of colonized peoples (Fanon, 1967; Keller, 2007).

The assumption that aid recipients are “poor people” whose poverty necessarily puts them in survival mode, and who consequently cannot think at a “high level of abstraction,” supports such an interpretation.

Instead of seeing these two interpretations as mutually exclusive, however, we might instead understand them as two simultaneously operative intentions, or repertoires. I was convinced at the time of interview that she was not intentionally trying to put down her beneficiaries’ intelligence. She seemed, rather, to be trying to speak as honestly as possible about what she perceived as the psychological consequences of lifelong material poverty. But her words raised sensitive questions about how aid workers should speak of their beneficiaries’ subjectivities. As Alastair Ager has argued, “there is no comfortable ground [for aid workers] in this territory” (1997, p. 404).

Increasingly mindful of critiques of trauma-focused interventions, researchers and policy makers have sought to define a new disciplinary common ground on the use of PTSD with non-Western populations. A 2007 *Lancet* article about the politics of PTSD, authored by South-African and English psychiatrists, recognizes that “there are limits to the medicalization of distress” (Stein et al., 2007, p. 139). The article acknowledges critics’ concerns about the application of PTSD to parts of the world where the diagnosis is not already recognized locally. However, the authors then seek a middle ground by broadly affirming the cross-cultural applicability of PTSD whilst admitting that “not all distress is pathological” and that “cultural and social factors can be important determinants of susceptibility to the disorder by shaping ideas of what constitutes a trauma” (p. 141).

A similar middle-ground position is conveyed by American psychiatrists Devon Hinton and Roberto Lewis-Fernandez in their widely cited 2011 meta-analysis, “The Cross-Cultural

Validity of PTSD: Implications for DSM-5.” Hinton and Lewis-Fernandez conclude their review of over 150 studies of PTSD by cautiously suggesting that the diagnostic category “constitutes a cohering group of symptoms that occur in diverse cultural settings in response to trauma” (p. 14). But what remains notably unaddressed in their account and in others is the extent to which the PTSD symptoms being measured capture those aspects of sorrow and loss that matter to those being tested for them. Pupavac’s and Summerfield’s critique on this point finds no answer in these literature reviews.

As Summerfield’s and Pupavac’s critiques suggest, debates about trauma-focused interventions are not simply about parachuting psychologists. The parachuting archetype articulates a caricaturized view of humanitarian mental health whose presence has alarmed aid workers worldwide, but as Alastair Ager argues in his 1997 account of “Tensions in the Psychosocial Discourse,” there is more to discuss than the parachuting psychologist.

In Ager’s view, one of the most important tensions that underlie humanitarian mental health was “the valuing of technical versus indigenous understandings” (1997, p. 402). We should be wary, Ager argues, of policy makers’ promises to usher in a new era of participatory humanitarian assistance. Interventions that promise to be holistic and participant-driven may conceal old inequalities behind participatory rhetoric. For example, even if mental health practitioners elect to increasingly downplay their own “technical knowledge” and permit entry to “indigenous understandings,” he writes, “which form of understanding exerts the dominant influence on programme goals, structure and reporting?” (p. 403).

Ager implied that “fixing” what ails humanitarian mental health is not simply a matter of eliminating references to PTSD or enacting broader interventions that are more community-based or that allow political issues to surface. Even holistic interventions, he argues, can still

privilege foreign over local knowledge; Western hubris is insidious and persistent in many stripes of aid work. To examine Ager's warning in greater detail, I now turn to the publication of the 2007 IASC guidelines for global humanitarian mental health interventions. The guidelines, I suggest, reflect the collective efforts of UN policy makers and larger international NGOs to move their field away from the parachuting archetype that has been its contentious frontispiece.

THE 2007 IASC GUIDELINES

Released in Geneva, Switzerland, in September of 2007, the *Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings* were written by representatives of 27 UN bodies and international NGOs, including the World Health Organization (WHO), the United Nations High Commissioner for Refugees, the American Red Cross, Médecins Sans Frontières (MSF), and the International Organization of Migration.

The 181-page document begins with a broad introduction to the humanitarian mental health field. "The composite term 'mental health and psychosocial³⁰ support,'" the first page states, "is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial being and/or prevent or treat mental disorder" (p. 1). Following the introduction are "action sheets for minimum response," each containing recommendations for how to assess mental health needs, how to recruit staff who "understand local culture," and how to attend to mental health needs in different humanitarian settings, including "food and nutrition," "shelter and planning," "water and sanitation (p. vii). The guidelines make a conscious effort not to segregate mental health from other humanitarian subfields; mental health considerations, they claim, should be made part of every humanitarian intervention: "these

³⁰ Galappatti (2003) traces the popular term "psychosocial" to a 1997 UNICEF-sponsored symposium on child soldiers. As the symposium's proceedings had noted, "the term 'psycho-social' underlines the close relationship between the psychological and social effects of armed conflict" (cited in Galappatti, 2003, p. 11).³⁰

guidelines were designed for use by all humanitarian actors, including community-based organizations, government authorities, United Nations organizations, non-government organizations and donors operating in emergency settings... these guidelines are not intended solely for mental health and psychosocial workers” (p. 6).

Noting the rise of mental health as a subfield of humanitarianism (see also Baingana & Bannon, 2004), the introduction declares the guidelines’ purpose as to provide a “multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another” (p. 1). This broad approach reflects the view that mental health cannot be separated from other aspects of disaster and war recovery. As one psychiatrist who regularly served as a UN consultant noted,

Many times it’s very, very difficult to separate mental stress and problems and problems that come from difficult life conditions. When you can’t feed your kids, you’re not able to be worried about how you express your anger. You do what you have to do to survive. So when [NGOs] go to work on the mental well-being of a place in crisis, [they] can’t work just with *mental* aid. You need other tools. Some organizations focus mainly on these other tools, either distributing food or opening shelters for people without homes to sleep in... many times those things blend.

The guidelines do not describe or allude directly to the parachuting psychologist archetype, nor do they acknowledge its role in their creation, except to laconically caution against “direct services.” But a widely-cited 2005 WHO bulletin about mental health in emergencies does allude to a euphemized version of the parachuting archetype (van Ommeren, Saxena, and Saraceno, 2005). The bulletin, which closely preceded and anticipated the guidelines, represents the WHO’s first official response to growing critiques of humanitarian mental health. The parachuting archetype appears there in barely veiled form: “Following disasters in resource-poor countries, foreign clinicians often arrive to promote PTSD case-finding

and trauma-focused treatment in the absence of a system-wide public health approach that considers pre-existing human and community resources, social interventions, and care for people with pre-existing mental disorders” (van Ommeren, Saxena, and Saraceno, 2005, p. 71). This bulletin berates such actions, and advises community-wide interventions, instead.

In the guidelines, an engagement with the parachuting archetype can be traced in less explicit ways. The guidelines’ authors are careful to emphasize early on that not all victims of emergency are to be thought of as traumatized. “In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity,” the introduction explains (p. 3). Departing from accounts³¹ that have justified mental health interventions with reference to the presumed global burden of mental illness, the guidelines avoid references to illness statistics, arguing that mental health and psychosocial support is needed not because emergency victims are likely to become mentally ill, but because all aspects of disaster and conflict recovery involve mental health.

Continuing in a broad vein, the guidelines then undertake to remind humanitarian workers that mental health matters are relevant to their work even if they do not specialize in mental health. The action sheet on “shelter and site planning,” for example, advises shelter planners that, “mental health and psychosocial problems can arise when people are isolated from their own family/community group or are forced to live surrounded by people they do not know” (p. 174). Therefore, it is recommended that planners “select sites [for displaced persons] that protect security and minimize conflict with permanent residents” (p. 175). This recommendation, in other words, is given as mental health advice, bringing the aid industry at large into its disciplinary jurisdiction.

³¹ Mollica et al. (2004) argue that “45% of the refugees studied met DSM-IV criteria for depression or post-traumatic stress disorder or both” (p. 2059).

Perhaps most striking about the guidelines is their lack of specificity in terms of both aid practice and theory. To an aspiring new practitioner, they are few recommendations for where to begin. Particular psychotherapeutic techniques are not addressed: cognitive behavioral therapy, psychodynamic therapy, pharmacology, art and music therapy, and counseling are never endorsed, proscribed or even mentioned. In their account of the guidelines' creation, Wessells and van Ommeren (2008) attribute such generality to efforts to foster consensus among practitioners from different disciplines.

Since the mid-1990s, write Wessells and van Ommeren, the field has been roughly split into two main streams: a so-called "health" sector emphasizing PTSD-focused interventions and staffed primarily by *psy* professionals following a biomedical model, and a "social welfare" sector emphasizing "holistic, community based approaches" that would strengthen local support systems (2008, p. 201). "These different camps," they write, have "competed for funding and rarely collaborated." Practitioners in both camps, they add, have "each adhered to their own approaches, offered competing analyses grounded in divergent theories, valued different types of evidence and often showed marked disrespect for opposing views" (p. 201).

The aforementioned WHO bulletin (van Ommeren et al., 2005) expressed concern about this bifurcation. Its authors called for the unification of the "psychosocial" stream of the field with the "mental health" stream, so that program planners would not find themselves facing the choice of setting up either vertical trauma-focused interventions or psychosocial ones that did not address mental health at all. The 2007 guidelines were clearly constructed with this unification in mind. Psychiatrists, psychologists, social workers, aid scholars and humanitarian administrators all co-authored the guidelines together. Their early meetings did address the meaning of mental health, but conceptual divisions that arose in the ensuing conversations, van

Ommeren and Wessells write, led the group back to practical issues: “keeping the focus on practice avoided dwelling on divisions, and made it possible to achieve consensus” (p. 207).³²

Yet despite this apparent agreement to “focus on practice,” the guidelines themselves recommend very few “practices.” Apart from bland exhortations to facilitate communication among civil society organizations and lend general support to families, there are no examples from the field that might clarify such directives to readers. The guidelines place a high burden on the reader to intuit the next steps and to unpack terms like “community building,” implying that their intended audience is likely mid-career practitioners in whose minds such broad directives would already trigger the relevant exemplars.

The generality of the guidelines makes sense when considering its interdisciplinary team of authors and broad audience, but it seems like an odd choice for a community aiming to “enable effective coordination” and “identify useful practices.” A more condensed form of the guidelines, a 40-page “checklist for field use” (IASC, 2008b) reads even more like a set of headlines with no story: “Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with each other,” says one. “Do not work in isolation or without thinking about how one’s own work fits with that of others,” says another. Such

³² In this chapter, I provide a truncated review of the construction and dissemination of the guidelines, as I did not have the opportunity to examine it in detail. While I did interview several guidelines authors, as well as several members of the IASC reference group, a team that was subsequently formed to handle their dissemination, I was not able to collect enough data to make for a compelling or coherent story. Wessells and van Ommeren (2008), senior members of the IASC guidelines writing team, have written a first-person account of their role in the creation of the guidelines, and of the history of the guidelines more broadly. There is also a wealth of information online in the form of public IASC reference group meeting minutes. However, these minutes typically offer brief glosses. For example, one document (IASC, 2008a) includes a section titled, “Institutionalization of IASC MHPSS [mental health and psychosocial support] guidelines.” It acknowledges in brief that “A key challenge has been decentralisation; those at headquarters may be working on institutionalisation plans, but that may not connect well to the field, and vice versa. Another challenge is staff turnover.” Beyond this brief, evocative statement, however, little else is written besides broad directives to send the guidelines to as many NGOs as possible and to “take opportunities to refer to the Guidelines in meetings and presentations” (p. 13).

generality, Abramowitz and Kleinman (2008) note, may ironically “encourage the very sort of fragmentation that the guidelines seek to discourage” (p. 224).

The guidelines do, however, make their sustainability-oriented, holistic agenda explicit on nearly every page. They endorse the “composite term *mental health and psychosocial support* (MHPSS) as the official new name for the field, which “serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches” (p. 1-2). Emphasizing the importance of avoiding “direct services,” the guidelines instead recommend training locals in psychosocial aid.

Good aid, according to the guidelines, consists of long-lasting, community-oriented interventions that range from provision of food to human rights advocacy on behalf of victims. The guidelines, indeed, place “basic services and security” at the base of an Abraham Maslow-inspired pyramid of needs. The next category above security is “community and family supports,” which are responsible for reuniting families and reinstating social institutions. Meanwhile, psychotherapy and pharmacological treatment are at the very top of the pyramid, described as “specialized services” that should be limited in scope to only the few disaster or conflict survivors who suffer from “clinical” symptoms.

Robert, the American mental health researcher and consultant who spoke of the ease of fundraising for trauma, suggested that this turn to sustainability reflected a broad process of reckoning in the field of psychology:

Psychology as a discipline, I’m afraid, is rather insecure, and as a result it has tried too much to take a single discipline approach. If there’s one thing we’ve learned about psychosocial wellbeing in war zones, it’s that the nature of well-being is incredibly holistic. And so if you’re not thinking about economics and livelihood, for instance, you’re not going to get very far, because people will tell you that their sources of distress are lack of money and inability to be a good mother, a good father, and to meet basic needs. So taking a multidisciplinary approach is absolutely essential... When you come in and assume that you know what the problem is, and assume that the main thing that

needs to happen is therapeutic counseling, or whatever [it is] that you're bringing, there's a tendency to undermine the supports that are already there. In other words, you're not even listening to what local people regard as the biggest problems, and not asking them, 'who do you ordinarily go to for help?' You're creating a parallel system of help, which is probably not going to be sustainable.

Holistic, community-oriented approaches to humanitarian mental health were not invented in the guidelines, but rather long preceded them. In 2003, Ananda Galappatti, a psychosocial worker and scholar, found 71 different forms of "psychosocial" interventions in Sri Lanka that year, including therapeutic services, training sessions to help parents teach their children to manage stress, the promotion of shared labor among community workers, creating "positive social and physical environments," training locals on children's rights, teaching young adults business skills, "obtaining birth certificates for children to give them access to education," and many more (p. 5-6). These interventions, he wrote, were so diverse, he argued that the "psychosocial field suffers from a lack of consensus" (p. 3). Speaking with over 200 mental health practitioners on the island, Galappatti found an active desire among them for a "grand framework to explain the field" which would reflect some "common understanding" (p. 11, 4).

Alongside the guidelines' broad sustainability message, there is a subtle but consistent emphasis throughout the document on "rigorous needs assessment" and on "evidence-based" aid. "In Western societies, many people use complementary medicines, including unorthodox psychotherapies and other treatments (e.g. acupuncture, homeopathy, faith-based healing, self-medication of all kinds) in spite of a very weak scientific evidence base," the guidelines note critically under the action sheet heading, "Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems" (IASC, 2007, p. 136).

"Scientific evidence regarding the mental health and psychosocial supports that prove most effective in emergency settings is still thin," the guidelines note in their introduction. "As

this emerging field develops, the research base will grow” (p. 2). In the following section, I describe the context for these references to evidence and rigor, contrasting them with sustainability imperatives.

NOTIONS OF EVIDENCE IN MENTAL HEALTH RESEARCH AND PRACTICE

In 2004, a Lancet article bearing the title “Mental health in complex emergencies” made waves in the global mental health community. Its authors, Harvard psychiatrist Richard Mollica and several of his colleagues, argued that mental illness played a prominent role in the global burden of disease. “Depression, the fourth leading disease burden in 1990,” the authors wrote, “is predicted to move to second place in 2020.” But tackling this burden using mental health interventions, they argued, had been hampered to date by “the absence of guidelines linked to a formal system of assessment and monitoring [and by] the absence of criteria for evidence-based best practice” (p. 2060).

This perceived dearth of evidence and monitoring served as a rallying cry for researchers and policy makers who embodied with what Kurt Danziger (1997) has wryly called psychology’s “wishful identification with the natural sciences” (p. 9; see also Danziger, 1990). For them, the parachuting problem was less about the hubris or ignorance of practitioners than the absence of scientific evidence regarding what interventions actually worked. As they saw it, the much-maligned fly-ins were likely doing short-term therapy because that was what they believed to work back home. These parachuters must not have realized, in this view, that new methods, and new forms of evidence, were necessary to establish a canon of beneficial, empirically-proven *humanitarian* practice.

The vagueness of the psychosocial category posed an additional worry to these researchers and policy makers. The field seemed increasingly difficult to define when its

practitioners carried out interventions as diverse as cash-for-work programs and human rights advocacy. As Joao Biehl and Peter Locke (2010) note with respect to post-war Bosnia-Hezegovina, “NGO workers regularly told [us] stories of people appearing at psychosocial activities to ask for money or materials to rebuild damaged homes or to buy food for a few days” (p. 329). Policy makers and researchers responded to such diversity with a wide array of white papers and guideline documents that promoted various notions of evidence. One example was the Psychosocial Working Group (PWG), an international consortium of US- and UK-based academics and practitioners. Established in 2000 and disbanded several years later due to a lack of funding, the consortium managed in a short period to produce several research papers, bibliographies, and guidelines for field practitioners. Some of the PWG authors later went on to serve as consultants or authors of the 2007 guidelines.

In language that strongly anticipates the guidelines, the PWG defined psychological well-being as comprised of three overlapping spheres: human capacity, social ecology, and culture and values (PWG, 2003). Practitioners were called upon to be cognizant of the linkages between the three spheres, rather than being narrowly focused on the individual. Apart from this nod to holism and community-oriented interventions, the PWG warned of the field’s “lack of consensus on goals, strategy and practice,” attributing it to “a lack of clear linkage between idiom of assessment and means of intervention.” As long as this linkage was weak, these authors argued, “the prospects for establishing a clear evidence-base to inform developments in the field are poor.”

Importantly, the PWG does not elaborate upon what is meant by evidence, nor do its authors propose which actors would be best positioned to conduct such research, or who should fund it. Nor do the 2007 guidelines: while they repeatedly emphasize the importance of

evidence, there is no explanation throughout the entire 181-page document of what evidence might be sought, how it might be collected, and how it may inform future humanitarian practice. Recent critiques of humanitarian mental health contain similar omissions. For example, Peter Ventevogel and his colleagues (2011) link the field's absence of consensus to an absence of evidence: "the wide range of opinions about what should be done [in the field] is partly related to the absence of a solid base of evidence on the results of MHPSS interventions in complex humanitarian emergencies" (p. 197). Similarly, in their 2008 chronicling of the guidelines' emergence, Wessells and van Ommeren describe the two warring health and social welfare clusters of humanitarian mental health fighting ceaselessly, without an impartial mechanism for reconciling their differences. "In the absence of a solid base of evidence," they write, "dogma often dominated within these groups, limiting efforts to collaborate" (ibid).

The last two articles both attribute the field's lack of consensus to a lack of evidence, and not to other factors that might also be considered important, such as the community's diverse disciplinary backgrounds or the wide geographic spread. This implies that any fragmentation or disagreement about what counts as good aid is merely a technical problem, and that if an evidence base existed, practitioners would gradually fall in line with it, and consensus problems would diminish. This impression is reinforced, for example, by associating "non-evidence-driven" practitioners with "dogma," as though evidence chasers were immune to dogmatic allegiance to their ideas. What is not acknowledged in such an account is the possibility of numerous, possibly conflicting, bases of evidence, nor do the authors consider the existence of non-evidentiary factors, such as funding and conflicting stakeholder interests, as ones that might influence whether and how research translated into practice.

Like the 2004 Lancet article and the 2007 guidelines, neither Ventevogel and his colleagues (2011) nor Wessells and van Ommeren (2008) define evidence. This lack of specificity may indicate several things: a silent consensus on what kinds of evidence should be gathered, a desire to delegate the contentious task of defining evidence to those who would actually conduct the research, or simply an acknowledgement of the newness of the evidence-building paradigm and the importance of agnostically allowing it time to form. Such agnosticism would be understandable if not for the fact that equally “evidence-based” studies can yield contradictory recommendations for practice. In addition, what might count in the eyes of some researchers as high-quality evidence could, and often has been, dismissed by others as poor research.

It is not clear, moreover, whether these widespread references to evidence are referring to randomized controlled trials (RCT), wherein disaster or conflict victims would be randomly assigned to different experimental and control conditions, enabling researchers to separately test the effects of particular manipulations on predetermined symptoms of well-being (Thabet, Vostanis, & Karim, 2005); or perhaps to interventions that have been tested on American or European undergraduate students, who often constitute the most readily available subject pool in the social sciences. The latter would raise question regarding the applicability of Western-validated measurement instruments and treatments to non-Western disaster and conflict victims. Complicating the story even more is the fact that researchers disagree widely regarding what counts as a “systematic” study or an experimental method.

As Wietse Tol and Mark van Ommeren (2012) note in their review of the literature, most scientific evidence regarding mental health interventions to date pertains to “specialized interventions for PTSD and depressive outcomes” (p. 1; see also Tol et al., 2011) which have

increasingly been pushed out of the 2007 guidelines as “unsustainable.” Meanwhile, they argue, “very little evidence exists [regarding] community-based supports, structured social activities and child-friendly spaces [even though those] are among the most popularly implemented” (ibid). Tol and van Ommeren call for randomized controlled trials to test the efficacy of community-wide interventions. They caution, however, that “although the RCT remains the gold standard also when evaluating social interventions, much more preparatory work and adaptation is required” in order to study them, such as “multiple time-points in order to conduct multi-level analyses” (2012, p. 1-2).

I turned to my informants to ask how they understood the term “evidence-based.” Some practitioners were quick to say that *their* work was evidence-based, but few of them could name any particular evidentiary foundations or schools of thought to which their work ostensibly belonged. To them, the term seemed a bland but obligatory proxy for broader notions of science or modernity, which they knew they had to affiliate with but which had little to do with the context-driven work they conducted every day with aid recipients. Meanwhile, for other practitioners, “evidence-based” seemed more specific: it signaled that they were not just doing whatever interventions they felt like doing – the folly that had become associated with parachuters. Rather, they were assuring me that they abided by strict quantitative metrics and donor requirements. Their own uses of evidence thus seemed a subtle proxy for notions of systematicity and rationality.

As Anna Geltzer (2009) has noted, even though evidence-based medicine (EBM) “has been described as a standardization movement,” there is considerable debate surrounding what, precisely, EBM means (p. 526). In a study of underfunded post-Soviet medical bureaucracies, Geltzer addresses “what it means to talk about practicing evidence-based medicine in a setting

where the context of practice presents considerable barriers to the implementation of EBM principles” (2009, p. 526). She argues that Russian physicians use the term often to assert their own professional authority and expertise despite the absence of local conditions to test, utilize or draw upon EBM principles. Aid zones, I suggest, are somewhat similar in that they also constitute settings that present barriers to the creation of evidence and the implementation of evidence-based work – not simply due to the patrimonial bureaucracies and low funds present in Geltzer’s (2009) study, but also due to the unique constraints of each disaster and conflict zone. Some of my practitioners clearly understood these limitations, yet kept referring to evidence, strengthening my suspicion that the term “evidence” took on a broader meaning for them.

Other informants were critical of what they considered a narrow obsession with evidence in the field. Robert, the American mental health scholar who had co-authored the 2007 guidelines, argued that, “the entire field, the entire sector lacks a strong evidence base. Most of the interventions that are being used are various shades of empirically unproven, and it doesn’t mean that they’re horrible or ought to be thrown out the window. But they should be viewed with an appropriate dose of humility and caution.” The problem, he continued, was that prominent researchers and policy makers had adopted a narrow view of evidence, and were seeking to do away with anything that did not fit it: “This hard-nosed school of science says, ‘well, if you’re not willing to get people in, let’s say, Liberia or the DRC, access to the latest empirically proven psychotherapy, you’re in essence denying their human rights. You’re not giving them the best of Western science and you’re screwing up in that way.’”

Robert strongly disagreed strongly with this reasoning, and suggested that a more “appropriate standard of evidence” would be to go into the field and ask locals what they wanted. We should not “assume that it’s trauma and depression” that most needed help, he said. A

psychiatrist from the Balkans whom I shall call Marika echoed Robert's critique. She had worked in the psychosocial sector in Kosovo for nearly two decades, and had witnessed the devastations of the 1990s war. During our interview, Marika questioned the notions of evidence that underlay her donors' growing demands for program evaluations:

I see that the evidence is so meager for psychotherapy in normal, regular circumstances, that sometimes really I ask myself, why are we educated so much? Is our work really as efficient as we present it? [Or] could my intervention be replaced by some other intervention which would be less expensive? Because natural healers, I would say, can help lots of other people without being psychiatrists or doing any psychotherapy... When I started to work in these programs for children affected by wars, by terrorism, I was often angry when donors or some scientists wanted proofs that the programs were efficient. Because it's very difficult to provide such proofs. I cannot prove that [my programs] were efficient, but I think that these methods of evaluation have little relevance for the impact of a program. I think that the impact is much more on the side which is not measured: the energy invested by people. Simply making a person feel better or making a child feel happy is not the same as having an impact on symptoms... we don't measure the right things.

Marika and Robert both worried about the potential for policy makers and donors to fixate on measurable things at the expense of broader assistance. Their specific fear was that donors would make funding contingent upon NGOs' compliance with a narrow definition of evidence-based interventions, and that the latter would in turn increasingly design interventions primarily to win donors' approval – both of which they both said were already happening.

One informant whom I shall call Rory exemplified a different understanding of evidence. A semi-retired psychologist in his 60s, Rory had sought work with MSF's Spain branch partly to escape his professional life back home, he admitted with some humor. In 2011-2012, he was assigned to spend about a year in the West Bank supervising a team of young, primarily European psychologists treating Palestinians for distress relating to the Israeli military occupation.

One of Rory's first MSF missions had been to treat an Ebola outbreak in a Ugandan village near the Congo border. He had joined this mission as the only psychologist in a medical team, and his job, he recalled, was to help the community deal with the stigma of Ebola and with bereavement. One case in particular had stuck in his memory. A village family had had the money to educate only one of their daughters; many relatives had pinned their hopes of a better life on her success. But she died of Ebola a day after he arrived. The tragedy stunned everyone, extinguishing at once their hopes that the crowning glory of their family would be protected from harm.

After her death, Rory drove the young woman's mother back home from the hospital to their village, a few dozen thatch houses on the edge of a cliff. As the car approached the edge for the first time, Rory recalled, he saw the sun setting over the horizon in the distance, yielding a breathtaking view. At this very moment, the mother, who had until then been silent, started screaming in grief. Immediately, everyone in the village came out of their houses and started screaming themselves, and rolling on the ground, he recalled. It had seemed almost like a call and response, he said, an amazing contrast between the anguished rolling on the ground and the beauty of the cliff sunset.

Leaving the family to grieve, he began to walk around the village and tried to do what he described to me as "psychoeducation." First, he joined his colleagues in telling people to bury the dead deep in the ground and to cover their bodies in plastic and lime, because the recently deceased, he said, were the most contagious. It was "delicate business," he recalled succinctly, "to blend this with their burial rites." He then made various efforts to tell locals that they weren't being punished by God, and that their deaths weren't a sign of witchcraft.

Rory described his activities in Uganda as equal parts improvisation and common sense. In his telling, what he had done almost needed no explanation. He seemed almost baffled by my questions about what had motivated his choice of actions: “You go around talking to people. Give some financial support. Help them find local support. Talk to the community. Explain why a child died, to get rid of myths about witchcraft. You explain it’s a biological germ, it’s not them being punished by higher powers. You tell them it’s ok to cry.”

This story became important some minutes later, when, turning to the notion of evidence, Rory then conceded that in emergencies, there were “no perfect scientific conditions” to test and see whether something has worked or not. Randomized controlled trials were difficult, if not impossible, to conduct in aid settings, he said, but he insisted that “we need more transparency, more evidence-based or at least evidence-informed interventions.” Asked to clarify the difference between the two, he said, “CBT³³ is evidence-based. It’s in fact the only thing that’s been shown to work with trauma.” There were many CBTs, he added: acceptance commitment theory, dialectical behavioral therapy, anxiety therapy, and many others. Unfortunately, he added, “circumstances and variability in training mean that CBT is not used routinely in humanitarian settings.”

In contrast, *evidence-informed* interventions included things like psychological first aid (PFA), which the World Health Organization defines as a “humane, supportive and practical help to fellow human beings suffering serious crisis events” (2011, p. ii). PFA, the WHO (2011) emphasizes, is not the domain of specialists; it is something anyone can do to comfort others in distress. Rory explained: “we have no direct controlled studies on PFA, but we do know it’s a good standard first response,” since “it’s based on very sound principles that are partly

³³ Cognitive behavioral therapy.

commonsense, but also we know based on related things that they work.” Unfortunately, Rory lamented, a lot of the interventions he saw in the field weren’t fit his notion of what counted as evidence-informed work. As he argued, “counseling is not therapy. Just asking people to talk about their feelings has not been proven effective and can even harm, like debriefing.

Psychoanalysis doesn’t help.”

As Rory continued to critique what he perceived as the unscientific, what-feels-right approaches of many of his contemporaries, I recalled his earlier story about Uganda. Had he not been similarly doing “what felt right” during his time there? I asked. “Yes, well,” he responded with some embarrassment, “this was a short-term thing, a one-man team.” He had tried to be “careful” even then, he added. His objection, he soon clarified, anxious to seem consistent, was not to counseling or talking per se, but to basing entire interventions on it. Yet it was not clear from his narrative where the line was to be drawn between “real” interventions and “short-term, one-man team” missions of the sort he had done in Uganda. He appeared to be drawing, then, on two distinct repertoires (Gilbert & Mulkay, 1984) in his discussion of humanitarian work: when reflecting on his own missions, he seemed highly attuned to the contextual indeterminacy of frontline work and the need to improvise in response to local needs. Yet when he spoke about the field at large, a different repertoire emerged that stressed the importance of evidence and the suspect nature of “common sense” as a guide to humanitarian practice.

Rory conceded that some of his contemporaries might find “evidence-based” interventions too “Western” to attend properly to locals’ needs. In an effort to rebut such critiques, Rory presented cognitive behavioral therapy, a set of techniques that emphasize changing people’s behaviors in order to improve their wellbeing, as an intervention that had the best of both worlds: it was both evidence-based and culturally sensitive. He gave a simple

example: one of his supervisees had been treating a Palestinian woman whose male relatives were imprisoned in Israeli jails. She had been feeling profoundly depressed, helpless, and uncertain of her family's future. In one therapy session, the young practitioner asked her what she valued most in life. Being a mother, she responded. And what do you value most about being a mother? He asked. Cooking, she replied, but lately she had felt too depressed to cook for her children. Then go to the market this evening, buy ingredients, and cook a meal for them, the young practitioner had counseled.

However trivial these directives might sound, Rory said, simple forms of behavioral activation did work. "You get people moving: that is therapeutic," he said, adding that while CBT could not easily treat Palestinian's ongoing trauma under a persisting military occupation, the Palestinian mother's symptoms did improve significantly. His mentee had created a good adaptation of a Western method to the Palestinian context, he concluded, "because it's evidence-based, but from the *woman's* point of view." At the same time, he added a bit later as an afterthought, some NGOs had undertaken too much of a corrective pursuit of culturally sensitive methods to the detriment of everyone involved – like incorporating local healers into their programs. "We still use Western methods to treat malaria, not witchcraft," he said, adding, "I'm not saying West is best. I'm talking about science."

Divergent, and at times contradictory, understandings of evidence can be detected in Rory's account. On the one hand, his enthusiasm for evidence-based practice is clear. He is openly critical of interventions that consist of improvisation, doing what feels right, or "just talking to people." On the other hand, his description of his Uganda mission not only contained practices very similar to those he later denounced, but in his own account of Uganda, common

sense and improvisation were important categories by which he seemed to understand his work there.

Another perplexing point in Rory's story is the notion of evidence-*informed* practice, which he cautiously endorses as a "good-enough" temporary substitute for evidence-based practice. Interventions that are evidence-informed could, according to his description, consist of almost anything. Yet this possibility does not seem to faze him despite his concern for the ontological integrity of evidence. Rory also takes pains to argue that evidence-based interventions should not be understood as synonymous with "Western," and to show that they can be adapted sensitively to the Palestinian context. At the same time, he perceives his contemporaries' excessive pursuits of cultural sensitivity as leading the field away from "science."

Such inconsistencies are not unusual. Indeed, Rory's account, like Robert's and Marika's, shows that evidence invokes more diverse, conflicted meanings than the policy documents that herald a new evidence-based era would suggest. For many practitioners in mental health and in other humanitarian domains, "evidence-based interventions" have become the most promising solution to humanitarian assistance's long-standing efficacy and coordination challenges, even as the precise meaning of evidence have remained deeply contested and in many cases, underspecified or poorly understood. But evidence has not only been taken literally to signify the systematic pursuit and dissemination of research findings. Rather, it has also been invoked also for its connotations of rationality and systematicity.

RATIONALISM AND SUSTAINABILITY IN THE GUIDELINES

The 2007 guidelines' generality, I have argued, implies that they are not meant to guide frontline practice in a literal way. No specific psychotherapeutic techniques are recommended

beyond vague references to “compassionate, emotionally supportive care” (p. 116). Instead, broad exhortations are made to understand aid settings not as individuals walking around in a traumatic state, but rather, as an agglomeration of diverse groups, interests, and systems of care. The guidelines remind practitioners, for example, to take part in organizing temporary shelters for families until their homes can be rebuilt (p. 111), direct people to general health centers if they appear in need of medical help (p. 116), and remind local leaders and NGOs to “alert health care providers when they encounter or are informed about people who seem very confused or disorientated [or] have strange ideas” (p. 125). The guidelines are framed broadly, I have suggested, in order to seem applicable not only to psychiatrists, psychologists, or social workers, but to anyone, professionally trained or otherwise, who considers herself invested in “mental health and psychosocial support.”

Indeed, as I have shown, the guidelines take pains to blur the boundaries between mental health and other forms of care, implying that mental health is something every aid worker should know and care about, and that attending to it is an obligatory part of entering a disaster or conflict zone. In other words, the guidelines de-professionalize humanitarian mental health. The growing prominence of psychological first aid as a tool to be used in aid settings supports this contention. The WHO’s PFA guidelines (2011) describe PFA as “help,” not therapy or “treatment,” and explicitly directs itself to non-professionals. “Perhaps you are called upon as a staff member or volunteer to help in a major disaster,” the PFA guide begins, or “perhaps you are a teacher or health worker talking with someone from your community who has just witnessed the violent death of a loved one. This guide will help you to know the most supportive things to say” (WHO, 2011, p. ii).

The guidelines, therefore, appear to promote not particular forms of practice but rather broader modes of being, wherein practitioners are working seen as political actors working with local governments and getting involved in reconciliation and reconstruction efforts. This representation is a far cry from that of mental health experts narrowly deploying their particular professional expertise in order to treat individuals. This apparent effort to disassociate the guidelines from the parachuting archetype, with its connotations of narrow, non-collaborative, Western treatment, in other words, appears to have resulted, intentionally or otherwise, in an exceedingly interdisciplinary set of directives that do not attempt to make mental health needs medical or apolitical – contrary to the critique that Derek Summerfield (1999) and Vanessa Pupavac (2001) have often made. Rather, the mental health worker envisioned in the guidelines seems a jack of all trades who does not shy away from grassroots political work on the ground. The following quote from an interview with Robert, the mental health scholar and guidelines co-author, exemplifies how such thinking might work in practice:

When you actually talk to people about how they respond to their problems, they have elaborate peer-based systems, or they may have traditional systems that can help them, tools and so on. And they have women's groups, religious groups, youth groups. Lots of people who are fervent followers of Islam say "my Islamic faith is what has enabled me to cope, to survive." So I think this tendency to go in and not build on what's already there is unfortunate in a couple ways. Number one is it tends to marginalize the good supports that people are already using. Number two, it creates a parallel system of support that has money and power attached to it. And so people naturally start going with that. If I was starving or if my family was starving, there's nothing I wouldn't do to make sure I lined up to demonstrate trauma, depression, anxiety. Tell me what you want me to exhibit, and I'll exhibit it. Anything to get help for my family.

As Robert suggests here, practitioners must understand the political subtext and power dynamics of the settings in which they work, and to recognize that locals might resist interventions or comply with them for reasons unrelated to their content. While this may seem commonsensical, it reads as a profound departure from the medicalizing and individualizing practice that critics of

parachuting, Summerfield (1999) most prominent among them, insist is still happening. The sort of political awareness that Robert is describing takes time and experience – and tacit knowledge – to build, and is not easy to teach with field guides or explicit directives. This makes its inclusion in the guidelines all the more significant: what it means, I suggest, is that the guidelines are equating holistic and community based practice with interdisciplinary and political work that has little to do with the professional craft of Western *psy* disciplines (Rose, 1996).

Yet such gestures to holism and interdisciplinary, I suggest, clash with the guidelines' frequent references to "evidence-based" aid and "rigorously conducted assessments" (2007, p. 43), which are repeatedly mentioned but never explained, defined or exemplified. It is unclear how meetings with local leaders could be subjected to "rigorous" assessments of efficacy or need; nor how family reunification efforts could be made "evidence-based." Overall, then, the bill of goods being "sold" in the guidelines is unclear. From one perspective, the guidelines' two-pronged emphasis on scientific evidence and sustainability is not necessarily contradictory; it is certainly possible to imagine community-based interventions being designed based on studies that would satisfy many researchers and policy makers. At the same time, the guidelines provide numerous subtle directives for political action that, I suggest, could only be made by acknowledging the fundamental indeterminacy and contextuality of humanitarian work, and the discretionary power that practitioners must have in order to do it (Lipsky, 1980). The guidelines, for instance, advise working with local governments. The vicissitudes of such painstaking work do not lend themselves easily to experimental efficacy tests, predetermined directives, needs assessments or minute oversight of aid-giving activities.

In this chapter, I have attempted to show that the self-conscious efforts of humanitarian mental health policy makers to distance themselves from the parachuting archetype have resulted

in a bifurcated ideology of change. One of its prongs has framed the ills of parachuting in postcolonial terms as a dearth of cultural sensitivity and over-emphasis on Western technologies of care. The other, in contrast, has faulted the perceived absence of science and of evidence. Nascent efforts to combine these visions in the 2007 guidelines have produced a complex 181-page white paper that, following anthropologist Kregg Hetherington's analysis of World Bank documents, we may consider an "exercise in institutional self-representation" that is akin to a "marketing brochure" (2009, p. 653). Admittedly, the guidelines' treatment of evidence and sustainability is not symmetrical: while the former is articulated in numerous ways through the text,³⁴ references to evidence and systematic needs assessments are sporadic and perfunctory. At the same time, I argue, they adumbrate an important wind of change.

Overall, the guidelines articulate competing visions of what humanitarian aid is meant to achieve (lower individual distress or community-wide rehabilitation) and how it is to achieve it (through evidence-based treatments or immersion in local communities, undertaken amidst careful negotiations with locals). These competing mandates, I suggest, can be attributed to the fact that, as I noted in the introduction to this dissertation, both rationalism and sustainability are rising humanitarian orthodoxies in their own right. When I asked a prominent mental health researcher and UN consultant, who had helped write the guidelines, what he made of these two different mandates and how he thought practitioners were expected to put both into practice, he told me that in his experience, practitioners read the guidelines "the way some people use religious books, in that they find in them what they believe and they do that. And they ignore

³⁴ Texts that wade into the rationalism/sustainability debate sometimes speak of sustainability, holism, and community-oriented work interchangeably, suggesting that these forms of practice have much in common (Abramowitz & Kleinman, 2008). Despite the slippage in terms, which may conflate divergent forms of practice, the main operational thrust of these descriptions, as Ventevogel et al. (2011) put it, is an emphasis on the need to integrate interventions into local healthcare system whilst collaborating actively with local bodies, instead of settling for short-term vertical interventions that do not strive for collaboration.

other parts of the religious books.” He lamented this selectivity. In the next chapter, I examine how policy makers and practitioners alike have attempted to put either prong of the guidelines – rationalism or holism – into practice. In doing so, I elaborate upon important omissions in the guidelines and describe how such omissions have influenced the field.

CHAPTER 4

PUTTING AID GUIDELINES INTO PRACTICE

Over lunch in San Francisco's Chinatown on a rainy November day, Aline, a prominent mental health researcher who had helped write the 2007 IASC guidelines, made a surprising claim about their utility. Asked what she considered the guidelines' most useful directive for frontline practitioners, Aline replied matter-of-factly, "of course the guidelines aren't *useful*. They're not meant to be." What mattered instead, she said, was that different people from different NGOs had gotten together to agree on basic principles. "Just because the Pope says something doesn't mean it's actually being put into practice by the practicing faithful, does it?" she asked. "What matters is that he said it."

Some months later, another guidelines co-author presented a somewhat similar and equally surprising view. "Much of these guidelines is kind of aspirational," he said. "They are written as if you are really super-competent and you have resources – all the things you should be doing. But the reality is none of us are that competent. None of us are that rich." These two co-authors' frank remarks highlighted the symbolic significance of the guidelines, irrespective of their utility or implementability in the field. As Alastair Ager (2008) has noted, the guidelines are "not just a political achievement;" rather, they are "a political achievement that secures a basis for improved coordination between agencies" (p. 262). It was important, he argued, to see "a consensus statement as a *rallying point*," irrespective of its actual content" (ibid.).

With this idea as a point of departure, this chapter explores some of the potential challenges of putting the guidelines into practice. The guidelines discourse described in the previous chapter suggests a global mission to reform a growing field whose boundaries are unknown and exceedingly difficult to regulate or govern. Yet few of my frontline informants in

2011 and 2012 had even heard of the guidelines. They were preoccupied, they explained, with the immediate demands of their daily work: securing the necessary permits for the opening of a community mental health center, arranging for additional funds to pay local staff, and advising a family to medicate their daughter's schizophrenia even though this might expose the entire family to ruinous social stigma. In the constant forward motion of daily practice, questions about evidence, sustainability, and methods often came across to most of my informants as self-indulgent or overly abstract.

Their bosses, my informants said, valued concrete verifiable indicators of success like numbers of patients treated and health centers built, not bland declarations of fealty to holism, evidence, or sustainability. In this chapter, I address the guidelines discourse's persistent agnosticism regarding the referents of these terms, examining why such ambiguities persist and how they have affected efforts to govern humanitarian practice. After providing a brief introduction to the guidelines' policy infrastructure, I describe ongoing struggles by mental health practitioners to define psychosocial aid and to articulate divergent forms of expertise in the field.

I then turn to two notable omissions in the guidelines: debates about the applicability of psychotherapeutic methods to non-Western aid settings, on the one hand, and the funding architecture of humanitarian mental health on the other. As I illustrate, the two omitted elements constitute important determinants of daily aid practice. Their omission, I argue, serves to depoliticize aid, stripping it from its economic and postcolonial contexts. In doing so, the guidelines imply that good aid is largely a matter of sustainability-friendly methods and willpower; in reality, however, limited funding and competing understandings of sustainability in

postcolonial settings render the guidelines' sustainability mandate considerably more complex to actualize.

ENFORCEMENT

“There is no humanitarian police,” explained the guidelines co-author who had described the guidelines as “aspirational.” The World Health Organization and IASC, he elaborated, had no official regulatory power, nor, practically speaking, the ability to sanction NGOs that did not comply with the guidelines. However, there were numerous other ways of exerting influence. Donors could, for example, withhold funding from NGOs that did not comply with these directives, and some donors, I was told, had begun to do so.³⁵ Yet even without explicit economic conditionality, many NGOs still wished to be seen as compliant with UN and WHO dictates in order to signal their membership in a global community of respectable aid-giving organizations.

“Reasonable-size NGOs are in what they call a ‘dialogue relationship’ with the WHO,” said a prominent UK mental health researcher with extensive WHO-affiliated projects, emphasizing the words “dialogue relationship” and their ironic connotation of equality. “They meet with the WHO once a year, so they are WHO-approved.” She herself was WHO-approved: “I have a module on disaster management. I got my [PowerPoint] slides approved by WHO because I wanted to be clear that they were in synch.” She had sought a WHO stamp of approval, she said, in order to assure would-be trainees of the quality of her work, and to differentiate herself from dozens of other practitioners with similar short-term training modules. One way in which the guidelines filtered through to frontline interventions, then, was through the

³⁵ Unfortunately, I was not able to find out which donors were doing this, or how they were defining or measuring compliance: this could have involved defining and periodically measuring specific performance variables, holding a monthly IASC training session at each compliant NGO, or simply giving a WHO logo to be affixed to the side of the NGO vehicles.

prestige and authority attributed to WHO- and UN-affiliated documents. Some practitioners took note of these and wanted to be seen as compliant with them.

But compliance with the guidelines' holism mandate often proved complex, in part because of the broadness of the psychosocial category itself. A psychiatrist who had once facilitated a UN aid coordination meeting in the West Bank gave an interesting example of this difficulty. This UN meeting had brought together representatives of foreign and local NGOs working in different cities in the West Bank, including Nablus, Tul Karem, Jenin, and Hebron. Each of them ran a psychosocial program. Coordinators had assumed, this psychiatrist said, that as long as all operations were running, mental health was thereby "covered" throughout the West Bank. But when asked more specific questions about their projects, representatives indicated that one city had a small microfinance program, while another ran psychosocial camps for children, and yet another supported psycho-education sessions on women's health. Different things were being done in each area, then, leaving important needs unmet.

My informants expressed varied opinions regarding the ambiguity of psychosocial category itself. One UK-based mental health researcher believed it was good that mental health practitioners were increasingly looking "beyond the individual at things like economic opportunities and social capital." At the same time, he argued, this movement had also ushered in a spate of NGOs who've "jumped on the psychosocial bandwagon," defining it however they like, taking advantage of budgets and grants for psychosocial aid and employing "lots of volunteers who lack expertise." Good intentions were not enough, he argued, and there were serious policy gaps that remained to be exploited: "even the IASC guidelines don't define what psychosocial aid means."

“Suppose you see a pot of money labeled psychosocial aid,” he continued, referring to NGOs, “then you’ll call your efforts psychosocial aid” in order to win the money. This kind of tweaking happened in every field, he acknowledged. But mental health seemed to him easier than some other humanitarian fields, like water and sanitation, to tweak in this way because notions like empowerment, healing, and community building were so ambiguously operationalized.

Robert, the guidelines co-author, disagreed with his assessment. “I have a different take,” he wrote in a personal correspondence. “Donors typically love it when applicants have set, proven indicators and can measure precisely.... I’d guess it’s far more common that donors turn away from psychosocial programming because of the lack of evidence, difficulties establishing outcomes and impact, etc. In fact, more than a few donors have told me that over the years.” Whether psychosocial aid’s conceptual fuzziness created more or less freedom to act for practitioners, then, proved a complex question. While several practitioners suggested that the category’s fuzziness encouraged diversification, others countered that donors’ demands for “verifiable indicators” of success acted to offset and significantly reduce the discretionary scope of the psychosocial category.

DEFINING PSYCHOSOCIAL AID

Perhaps due to the broadness of the psychosocial category, I ran into some early trouble when I tried to ask practitioners how they understood their own methods and techniques. One Israeli educational psychologist who had flown to Haiti after the 2010 earthquake burst into laughter when I asked him to elaborate a bit on his “methods” in the field. Well, he said, smiling, he had been hoping to do some clinical work in the displaced persons camps in and around Port-au-Prince. When he landed in Haiti, however, he was overwhelmed by the large

number of NGOs onsite, many of which seemed to him to be carrying out the same kinds of work in parallel, instead of in a coordinated fashion.

Sensing that therapy would be useless in this setting, he abandoned his plans and took a walk around the camps. His new “method”, he said with some irony, was simply to see what the NGOs were *not* doing. He noticed, for example, that hundreds of children were wandering the streets after their school had collapsed. He promptly hired a translator for Haitian Kreyol and set about scouring the camps for teachers who could teach these kids. No one had seemed to think of this, he recalled: a Japanese NGO was building a huge school nearby at the time, and some American NGOs were running play camps. But no one, he said, had seemed to think that an interim schooling solution might be important for the kids. Within a week, he and his colleagues had set up a makeshift school in several combined tents. Those were his “methods,” he concluded wryly, but assured me that they might have been “anything else that needed doing there.”

He saw his own work, in other words, as so broad and contextually driven that he found my attempts to nail it down apart from its context to verge on humorous. Several other practitioners reacted in similar ways to my questions. They seemed to take methodological eclecticism for granted; several accredited psychologists and psychiatrists, moreover, averred the methods they had been trained in were often useless to their daily work, which required not only a high adaptability to local contexts, but also a sensitivity to local political developments for which their methods and professional training were of little use.

The broadness of the psychosocial category was also reflected in job advertisements. Scouring hundreds of job postings for psychosocial work on sites like reliefweb.int, unjobs.org, and devex.com, I saw that postings typically made no mention of the applicant’s desired

expertise or methodological preferences (for example, cognitive behavioral therapy, art therapy, or psychodynamic therapy). Nor did they list desired academic qualifications or professional backgrounds. Instead, the typical wording merely asked for two, five or ten years of desired humanitarian experience in either “counseling” or “psychosocial” work, and then specified the spoken and written languages desired for the position.

I was eager to understand the reasons for this apparent categorical obscurity. For an executive director at a Tel Aviv-based psychosocial NGO, the organization’s “psychosocial” moniker was a utilitarian descriptor only. Pondering the nuances of this category, the director explained matter-of-factly, was not among her list of concerns, nor was musing about the relationship between “psycho” and “social,” or contributing to global debates about *psy* expertise. For her, rather, and for other informants, the psychosocial category signified simply interventions that targeted both individuals and groups – “psycho” and “social.”

This NGO, which I call Psychosocial Aid for Refugees (PAR), catered to asylum seekers from sub-Saharan Africa. It consisted of a bustling array of youth groups, vocational training programs, and advocacy work vis-à-vis the police and banks, which often refused to open bank accounts for refugees on the pretext of non-residency. Counseling constituted but a small minority of the NGO’s mission: most paid and volunteer staff, including the executive director herself, were not trained in mental health. “We find solutions for people one by one, drop by drop,” the director said when asked to describe what her NGO strived to achieve. “Personal contacts for hospitalizing someone with a mental disorder. Single moms. We deal with Mesila [a Tel-Aviv municipality-run welfare agency] primarily for children. But Mesila won’t help an older asylum seeker who is homeless and sleeping in Levinski Park, so we try to find him places to sleep.” Such actions struck me as strongly reminiscent of AHE’s *combinot*. “Our ability to

solve problems is small,” the director added. “We might find shelter for someone but not treatment, or vice versa. It varies from day to day. We aim for a broader vision than just treatment. We have a youth club in afternoon, to provide young people with a social outlet. A support and advocacy center, providing information, orientation trips.”

This NGO director’s matter-of-fact description implies that she was focused on concrete daily action, rather than given to ruminations about what forms of expertise psychosocial practitioners could lay claim to. However, such questions *have* attracted considerable attention in the field at large. In particular, the term “counseling,” commonly used both as a synonym for and subcategory of psychosocial aid, has become the focus of competing views about its utility in daily practice.

COUNSELORS AS HUMANITARIAN LABOR

According to three practitioners had worked in Palestine, Kosovo, and Uganda, respectively, “counseling” was a useful term for NGOs involved in mental health: it allowed international organizations with nominally strict hiring criteria to employ local staff who lacked official educational credentials. Calling local staff “counselors” could effectively silence questions from above about their training, enabling far-away supervisors to maintain (or claim to maintain) universal hiring criteria even as managers and practitioners below them continued to hire employees without official diplomas. On the surface, this seemed to suit everyone, allowing frontline managers, who were more likely to value “what people do on the ground, and not their credentials,” to hire people they thought could do a good job even if they lacked official credentials, while their supervisors had enough distance to be able to claim ignorance of these hiring practices should they be called upon to justify them. This was a good illustration of the

kind of loose coupling (Orton & Weick, 1990) and manager-frontliner collusions (Lipsky, 1980) that the broad psychosocial mandate encouraged.

The flexibility of counseling, then, was useful in opening up jobs to local staff who lacked institutional accreditation. At the same time, since many aid actors knew that “counseling” was a catch-all phrase that could be used to circumvent hiring policies, the term had a stigmatizing effect, affirming local staff’s lower credentials while making it convenient for international NGOs to refrain from providing them with expensive training that would yield credentials that mattered in Western institutional settings. If they can get away with using locals as “counselors,” Barry, the American psychologist working in Kosovo, pointed out with sarcasm, then why bother establishing expensive training programs that might give locals real credentials they could use once the project was over? “MSF has been able to help individuals, certainly,” said Larena, a psychologist who worked in the West Bank, of the NGO’s mission there. “But they haven’t changed the infrastructure that could really help this society treat their own problems. Had they trained five good psychologists [in Palestine] who worked first at MSF, then they could have worked in other organizations.” That, she added, “would have been something I would consider to be development.”

Such training would have to be largely informal at first, Larena added, but even that would have been superior to the status quo, as universities in the West Bank by and large lacked the capacity to train clinicians at the master’s degree level. MSF did not like to admit to having separate hiring standards for international and Palestinian mental health staff, Larena argued, as it conflicted with the organization’s desire to project an egalitarian image. In this sense, the term “counseling” proved convenient, allowing MSF to cut costs by not providing advanced training, while seeming to hire staff of equal or at least equivalent credentials. Alternatives to local

training, Larena explained, could include sending Palestinian staff for training in Europe. But few NGOs were willing to bankroll such training, she observed, especially in view of the fact that many previous trainees sent abroad had not come back home. The few who did were in such high demand that international NGOs were fighting each other to hire them.

The counseling category, then, exemplifies some of the broader tensions that underlay psychosocial aid's flexibility as a category of humanitarian intervention. The rise of "counseling" had made certain jobs available to locals who otherwise would not be able to obtain them. This, my informants conceded, was often good for local populations, as it meant that those with nuanced local expertise who generally best understood their problems were often able to assume important roles in an intervention. At the same time, such roles could periodically be choreographed from above as a friendly local face on foreign agendas that locals found hostile. Moreover, local counselors were not necessarily respected by supervisors: indeed, the category often came to symbolize patterns of inequality between expatriate staff, whose expertise was often taken for granted, and local staff who depended on foreign NGOs for employment and had little ability to either protest management decisions or seek promotion (Redfield, 2012). After learning about some of the labor politics of humanitarian counseling, I began to understand why Rory, the CBT-favoring psychologist from the previous chapter, had disdainfully claimed that counseling did not constitute true therapy. Rory's true objection, it seemed, was to the connotations of non-expert knowledge that he believed counseling to represent.

Ironically, then, the counseling category recapitulated some of the old "anything goes" connotations that had plagued the parachuting archetype, as "an activity that can be carried out by well-intentioned people with minimal training" (Horn & Strang, 2008, p. 295). Interventions that seemed broad enough to be consistent with the holistic mandate, and which had become an

indisputable part of the psychosocial infrastructure, also sometimes bore enough of a similarity to the vague, “non-expert” interventions that had concerned practitioners and policy-makers before the guidelines era, and that continued to dot the humanitarian landscape. To critics, then, the ever-broadening counseling category did not seem much like “reining in” the field. Rather, it had the potential, as a psychiatrist working in Uganda argued, to encourage a flood of poorly trained personnel. It was simply impossible in this climate, she explained, to know what a counselor was. The guidelines’ authors, I argue, in their decision to focus on practice and not attempt a theory of psychosocial expertise and knowledge, thereby deflected the problem of deciding what constituted psychosocial expertise to individual NGOs.

Alastair Ager, a mental health scholar and consultant at Columbia University who has written extensively about tensions in the psychosocial discourse, understands this difficulty well. In a 2008 paper titled “Consensus and Professional Practice in Psychosocial Intervention,” he writes, “it is widely acknowledged that the field of mental health and psychosocial support requires a sound evidence base for its further development” (2008, p. 262). But, he continues, what is the role to be played in evidence-building by “the ‘*expert knowledge*’ of senior practitioners who have worked across a range of emergency contexts over perhaps ten or twenty years?” In other words, “Is their learning inevitably unsystematic, anecdotal, and thus, an unreliable basis for judgment of effective practice? Some would agree. However,” he adds, “it is now acknowledged that such ‘expert knowledge’ is crucial in developing a field of professional practice. What is important is that such knowledge is dealt with in a manner that helps distinguish wise abstraction from personal prejudice” (ibid).

Mirroring the guidelines’ decided agnosticism about desired forms of expertise, Ager offers no concrete suggestions on how one might differentiate “wise abstraction” from the

“personal prejudice” of practitioners. Nor does he acknowledge the possibility that the contextual knowledge of practitioners might be easy to dismiss in a paradigm that venerates scientific research as the only form of legitimate evidence. At the same time, his work precisely underscores the ongoing difficulties of distinguishing expert and non-expert knowledge in the psychosocial field. Namely, references to evidence and rigor in the guidelines imply a science-based expertise, which is not consistent with the field’s *de facto* tolerance of experience-based expertise and broadly defined work responsibilities in the front lines.

Writing of psychosocial aid for Iraqi refugees in Jordan, Jane Gilbert (2009), a UK-based clinical psychologist and aid trainer, points out that counselors themselves were often uncertain about what counseling consisted of. For example, the psychosocial counselors she interviewed for the article were expected to hold supportive conversations with refugees, but they were also required to assess them for eligibility for financial assistance. That the same people in whom refugees were encouraged to confide had the power to deny them financial assistance constituted a conflict of interest, argued the counselors, which they felt undermined refugees’ trust in them.

I myself witnessed similar situations in which psychosocial aid workers’ efforts to give aid “holistically” periodically conflicted with the desires of aid recipients themselves. The guidelines’ holism mandate, which reflects an existing diversification of the field, dictates that it is not enough to simply hand recipients material commodities; rather, aid workers should strive to make a long-lasting difference in their lives. Yet sometimes recipients ask precisely for concrete commodities, and grow frustrated at aid workers’ “holistic” approach, which they read as patronizing or unhelpful. In the following section, I provide two such examples of these conflicting expectations, both drawn from the aforementioned psychosocial NGO, Psychosocial Aid for Refugees (PAR). In the first example, an asylum seeker comes into the NGO offices in

seeking food, while in the second, a group of asylum seekers meet with NGO staff, expecting to devise new ways of dealing with police violence and employment discrimination against asylum seekers. In both cases, recipients are startled at the sort of aid their benefactors have in mind.

PRACTICING SUSTAINABLE AID

In early summer of 2011, a young Eritrean asylum seeker arrived at the psychosocial NGO's offices in south Tel Aviv, requesting food. A small child was strapped to her back, and she clutched a large canvas bag in front. She seemed distraught even as her child grinned obliviously at everyone, but her request for food was not in itself unusual. The NGO carried a small supply of donated food items in a back office cupboard, consisting of items like bread, pasta, chocolate spread, jars of pickles and jam, and snacks. The quantity and type of food varied from day to day, depending on donations from food pantries, good Samaritans, or aid workers themselves.

Volunteers doled out food items at their discretion to asylum seekers who seemed desperate for food. It was typically a token amount. "We are not a food NGO," supervisors reminded volunteers regularly, emphasizing that such a meager supply of food as they could provide could not feed even one family for a week, let alone a community numbering in the tens of thousands. Other NGOs dealt more with food, they emphasized. More broadly, the reluctance to foreground money and food distribution was not unique to the psychosocial approach. Notwithstanding the rise of microfinance NGOs and cash transfer programs in recent years, the global aid industry has long been critical of money handouts as a stand-alone development strategy, and reports on the faults of one-dimensional cash aid, particularly its potential for corruption and dependency, are legion (Barnett and Weiss, 2008).

Whenever someone came in asking for food, then, volunteers were instructed to sit them down with a translator and gently try to get at the root of their problem. Maybe they needed help finding a job or shelter, or maybe they were refused a bank account at the local bank. Volunteers were reminded to always keep the bigger picture in mind, and never to simply hand out food and wave people away. Similar instructions were given regarding the petty cash account: supervisors guarded this pot of money carefully and doled it out sparingly, whether to help someone cover a month's rent or to buy a mother a second-hand crib.

Like the food, the money was to total no more than a “symbolic” amount, supervisors emphasized, to avoid the impression that the NGO was simply a charity. Their chief purpose, rather, volunteers were reminded, was to cushion the impact of asylum seekers' poverty and constant susceptibility to deportation, not to bankroll their daily expenses. “Helping means not just giving away cash,” I heard trainers say in volunteer training sessions. “It's a service for them to undergo this process of empowerment, so they will eventually be able to get along without us.” By “getting along without us,” aid workers did not mean long-term economic stability or acquiring refugee status. They referred, rather, to a more modest and temporary form of independence that included a bed in a shared apartment, a minimum-wage job, or access to education for one's children.

The NGO's volunteer training packet contained phrases that could have been taken from the IASC guidelines themselves, even though none of the aid workers I spoke with had heard of them: “It is important to emphasize that the treatment of cases, even if it seems specific, is always done as part of a wider perspective and an attempt to understand the individual as a whole – not to treat him as ‘a case’ [...] but to try to understand the whole range of his needs and capabilities,” the packet's introduction explained. A holistic understanding of humanitarian

work, the packet added, was absolutely essential: “Absolutely nothing is set in stone” about how aid work was conducted from day to day. Because of this, “it is important for us to view the person in a whole and comprehensive way [...] even if treatment of a particular case will amount to ‘only’ searching for a job for an applicant.”

Throughout the packet’s 23 single-spaced pages, respect for refugees as resilient, capable human beings facing complex problems was emphasized as a crucial personal quality of aid workers. “In order to receive applicants,” the packet assured new volunteers, “you don’t need to be a social worker! Working at the reception requires heightened sensitivity, empathy, and most of all, good-will.” When an asylum seeker first entered the room, the packet added, volunteers “should start the conversation making a short acquaintance with the applicant, and not with a direct question about his reason for coming. It is important to phrase yourself in a way that is enabling and not intimidating. Ask ‘how can I help you?’ and not ‘what do you need?’”

The packet soon turned to presumed cultural differences between volunteers and their recipients, adopting a tone that veered abruptly from hushed respect to paternalism. Noting that refugees might not easily open up about their problems, and might therefore require some careful probing, the packet proceeded to matter-of-factly explain why: “Not only is African culture much less direct than Israeli culture, but also the fact that we are a stranger to this person can slow down the pace of the conversation.” For this reason, volunteers should make sure that their “applicants” understand them well: “Sometimes we may need to repeat things several times and/or use a translator: ‘I will fax your forms to the aid center today. You will go there tomorrow at 8:00 in the morning. I will call you in one week from today to hear how things have progressed.’”

Volunteers should also remember, the packet noted, that some refugees were “illiterate” and needed things read to them (whether such illiteracy was in Hebrew, English or recipients’ native languages was not mentioned). At the same time, the pamphlet cautioned, “It is important not to belittle or undervalue the applicant. A person who speaks fluent English may feel that we are being disparaging to him and his intelligence if at every moment we check the level of his understanding.” The packet concluded by reminding volunteers that refugees “did not come out of nowhere. They have a distant and a recent past, they managed [for themselves] also yesterday, a week ago, and a year ago. In the absolute majority of cases, the applicants are mature and responsible adults with rich life experience, not a helpless population that needs to be protected.”

The training packet contains no date and does not name its authors. Like other documents of its kind, it is a collaborative effort that underwent several rounds of editing to reflect the organization’s evolving character. As an identity card for the organization, it embodies an important contradiction between empowerment and domination. While the pamphlet takes pains to emphasize refugees’ knowledge and agency, phrases like “in the majority of cases” abruptly undercut such statements.

Drawing on Marcel Mauss’ (1923) seminal work on the gift, Emma Mawdsley (2012) observes that “there is ambivalence in the performance of the gift – it must be offered as voluntary, disinterested and free, even as it sets an obligation at some future point to reciprocate” (p. 147). In the case of aid, the payoff may not be direct reciprocity from recipients to givers, but rather the creation of unequal relationships among them. Aid workers expect humble and grateful aid recipients, alongside an ability to claim the political capital of actors who have the means, and hence the power, to be generous. Aid, Mawdsley points out, thereby “produc[es]

moral orderings of superior and inferior, donor and recipient” in the guise of benevolence; in doing so, she writes, it “both signals and euphemizes symbolic domination” (p. 146, 148).

Notions of domination and inferiority coexist often in daily aid practice, as my discussion of patient privacy in chapter 2 illustrated. PAR’s training pamphlet, meanwhile, with its casual references to refugees’ illiteracy alongside their “rich life experience,” may seem like a rather trivial example by comparison. Yet its mix of tones – empowering and condescending at the same time – is a powerful illustration, I suggest, of how easily aid workers’ efforts to be empowering can become entangled in condescending language that unintentionally reinforces the helplessness of their beneficiaries.

When the young Eritrean mother came in with her baby asking for food, it was with this contradictory array of assumptions that PAR volunteers sat her down and warmly inquired after her living situation. They had seen her in the building many times, but did not know her well. Looking down at the floor, she seemed almost resentful at their questioning, and repeated through a translator that she had no access to food and no money. Are you homeless? they asked, looking at the child. No, she responded, saying she was living at a neighboring NGO-run women’s shelter. This NGO’s headquarters happened to occupy the same building, one floor above us. Hearing this, one veteran staff member was taken aback, and said in Hebrew quickly to the rest of us: if she’s sleeping there, then they should also be taking care of her food needs.

This staff member asked me to run upstairs to the neighboring NGO’s headquarters, and to ask their shelter coordinator why this woman was not receiving any food. The young mother, intuiting the gist of our conversation, became alarmed when she saw me rise to my feet. Her voice rose in protest as volunteers tried to assure her of their intentions to help her.

When I found the shelter coordinator upstairs and explained the situation, he was puzzled but compassionate. “I know her well,” he said, “She’s getting plenty of food, as far as I know. I wonder what’s wrong. Send her upstairs, I’ll talk to her.” When I ran back down, I found an angry scene in our lobby. The woman had backed herself against the wall with her child. She raised her voice in a yell as soon as she saw me, refusing to go upstairs. The volunteers were baffled, and when her translator tried to take hold of her arm soothingly, she violently pushed him away. At that moment, the large canvas bag she had been carrying suddenly fell to the floor. Its contents then spilled out unceremoniously: a few loaves of bread, a few cans of vegetables, and other modest staples.

Volunteers stood for a moment in awkward silence as the woman quietly gathered up her food and quickly left the office with her baby, not looking at any of us. For the rest of the afternoon, volunteers shook their heads in disapproval of her lie. She had plenty of food but said she had none, one volunteer told the rest incredulously. She was doing rounds among different NGOs, pretending to each that she had none so she could get some from everyone, said another indignantly. This is surely not her first time, another added. They smarted at her lie, not realizing that it was not uncommon for aid recipients to rework aid fit their own needs (Wagner, 2015). These particular aid workers had not heard of displaced Haitians who, after the 2010 earthquake, sold the tents the UN had given them for shelter in order to make some extra money to survive (Wagner, 2012). For them, the mother’s small lie symbolized a singular, pivotal loss of innocence (their own) and a fall from grace (of the mother, whose deceit has now placed her deservingness in question).

Other volunteers, however, felt differently about this revelation. In the face of a mother’s brute need for food, they realized, the NGO’s psychosocial mantra rang as a bit condescending,

not to mention stingy. Volunteers had believed they were acting in their beneficiaries' best interests by treating them as persons, not as outstretched hands and open mouths. They had sat the woman down to find out her story, not to simply hand her food. Seeking to respect her in this way, they felt, was a vastly more arduous and delicate path to follow. But this desperate young mother seemed to have little interest in such rationalizations. Her needs appeared more concrete and immediate: food, and lots of it.

Similar scenes in the weeks that followed exemplified a similarly well-meaning and unwitting condescension among aid workers struggling to deliver aid “psychosocially” – that is, with a focus on the “whole person.” For example, increasingly realizing that that aid workers were deciding too much what their beneficiaries needed, and thereby driving them away to Sudanese and Eritrean charities and assistance groups, PAR’s staff tried to calm growing tensions between the NGO and asylum seeker communities by recruiting two dozen Sudanese and Eritrean asylum seekers to form a joint “leadership” committee. This committee would ostensibly meet with the psychosocial NGO periodically to inform its staff about its community’s most urgent needs, so the former could make sure they were doing their jobs properly.

The first meeting, however, was an embarrassment. Thirty Sudanese and Eritrean asylum assembled in a large conference room borrowed from a nearby pro-peace NGO. Following a brief welcome, NGO staff commenced a series of ice-breaking games. Asylum seekers were divided into groups, each facilitated by an Israeli volunteer, and asked to hold a group discussion with each other about the cultural differences between Eritrea, Sudan, and Israel. The room fell mostly silent as volunteers haltingly began to facilitate these conversations, equipped with brief

conversation starters to aid them (“Did you know that in Sudan, Muslim males are circumcised in childhood, as opposed to in infancy among Israeli Jewish males?”).

Disdain and puzzlement slowly spread throughout the room. These ice-breaking games were not simply the introduction to the day’s meeting, asylum seekers gradually realized, but the meeting itself. “I am missing work for this,” said one. Missing even one shift could cost him his job, but he had thought this meeting would be worth it. Several of his group members despondently got up and left. Most of the others pushed their chairs back and began chatting casually with each other.

After several minutes, two young men got up and approached the NGO facilitators directly. Addressing the room at large, they began to list the concrete problems for which they had come: police violence towards refugees, unemployment, wage theft by employers, and the growing population of homeless asylum seekers sleeping in Levinski Park in south Tel Aviv. Let us talk about these, they pleaded of their benefactors in painstaking English. The NGO representatives tried to conceal their surprise at the adversarial turn the meeting had just taken. Clutching their ice-breaking sheets, they explained in friendly but firm tones that these issues would come in next month’s meeting. Today, they explained with forced smiles, was a getting-to-know-each-other meeting, and such divisive and difficult issues could not be dealt in the first meeting alone.

The meeting fizzled out quickly. Notwithstanding the NGO staff’s smiles and cheerful goodbyes to asylum seekers as they left, the room filled with a dull sense of wasted opportunity. It had taken months to persuade the thirty men and women to miss a day of work all at the same time. In their subsequent report to supervisors following the meeting’s conclusion, the staff spoke of the meeting in glowing terms, calling it a resounding success and noting its high

attendance and its atmosphere of a burgeoning partnership. They then mentioned in brief, delicate terms that some asylum seekers had not seemed to comprehend the NGO's broader mission. It looked like "everyone," they said, had some learning to do with respect to the NGO's philosophy of aid work.

Like the Eritrean mother, these asylum seekers desired concrete, immediate, targeted assistance. The NGO's version of empowerment, if this is what it was, struck them as self-indulgent when urgent, immediate needs were at stake. As with the Jordanian case in Gilbert's (2009) article, the ambiguity of the psychosocial NGO's mission created divergent expectations on both sides, which worked to deepen recipients' disappointment and mistrust.

I do not mean to imply that all psychosocial aid suffers from such myopia. Such follies manifest in numerous aid projects in diverse aid sectors. Moreover, numerous psychosocial projects do employ some kind of triage system to enable some urgent needs to be met immediately (in the form of cash-for-work programs, for example) while longer-term goals are pursued at a different pace in separate projects.

Instead, I mean to illustrate the unintended consequences of a turn to holism. Echoing James Ferguson's (2006) critique of aid skeptics seeking to save postcolonial subjects from Orientalizing accounts by calling them "modern," I suggest that the psychosocial mandate, despite its efforts to target whole communities and strain for long-term impacts instead of immediate goods, does not make aid workers immune to similar forms of condescension. In Ager's (2008) terms, valuing "indigenous understandings" was a delicate matter; it was not simply about constructing an intervention that aimed for an abstracted notion of "empowerment" drawn from practitioners' own aid imaginaries. Such work tended mainly to flatter the givers'

own self-image as new-era benefactors who did not patronize their beneficiaries or see them as anonymous victims.

Sarah White (2010) and Pablo Leal (2007) are critical of “participation” as a growing buzzword for aid and development. While the term began as a “counter-hegemonic approach to radical social transformation,” writes Leal (2007, p. 539), it has gradually lost its meaning by becoming operationalized as a series of techniques that could be enforced without genuinely participatory intent. The participatory approach had to be invented, he argued, to undo the bad feelings created by structural adjustment programs; the development industry had to “renew and reinvent its discourse and practice to make people believe that a change [had], in fact, taken place” (p. 540).

Yet quickly, the term was reimagined as “an instrument that could play a role *within* the *status quo*,” Leal continues (p. 543). For example, as White (2010) notes of Bangladeshi NGOs, meetings between NGOs and locals often assumed but a perfunctory role in an intervention, implying that locals’ desires and opinions were being taken seriously when this was often not genuinely the case. Yet locals were in a bind: if they did not attend them, they worried that they would not be able to complain about not being heard. “Participation,” in other words, became the “means through which existing power relations [were] entrenched and reproduced” (White, 2010, p. 6). While PAR representatives did genuinely hope to strike a participatory tone with Eritrean and Sudanese asylum seekers, meanwhile, they did not appear to be reflexive about the potential for such efforts to repeat the condescension of top-down interventions by other means.

GREY LITERATURE CLONES

So far, I have suggested that the 2007 IASC guidelines’ encouragement of interdisciplinarity, as well as their silence on particular forms of practice, appeared to perpetuate

some of the very uncertainties that their authors were hoping to bring under control. Despite this, many aid actors appeared confident that a convergence about best practices was gradually being reached, particularly through the endorsement of systemic, community-wide work over short-term, stand-alone clinical interventions (Ventevogel et al., 2011). As Robert, the guidelines co-author, put it, “If I could give you a single phrase, we’re at the stage still of international consensus building,” he explained. “The first step was consensus on the vision. And that’s the guidelines, on what needs to happen. But then another stage of consensus is needed, and that is on implementation.”

One means of implementation was dissemination, and the guidelines were quickly being disseminated to NGOs worldwide through white papers, press releases, donor directives, and meetings. Yet when I began to investigate their presence in NGO work, I noticed something odd: each psychosocial NGO or project already seemed to produce an abundant “grey literature” of its own about mental health and psychosocial aid. This literature did not necessarily describe that NGOs’ specific interventions in the field; in fact, usually it did not. Rather, each brochure, pamphlet, PowerPoint presentation or field guide seemed like a miniature summary of the 2007 guidelines (that did not necessarily cite them). Speaking in broad terms about mental health in disaster and conflict zones, virtually every document proscribed individual therapy or presumptions of trauma, and endorsed broad notions of resilience, holism and community-oriented interventions. Some also briefly referred to the importance of evidence and rigor, but only in very broad terms.

These brochures and manuals constitute a curious literary genre. Citation practices characteristic of academic writing, for example, were notably absent from them. With few exceptions, like a World Bank toolkit on mental health integration into local healthcare system

(Baingana & Bannon, 2004), these documents did not name their authors or contain any dates; and they did not cite any sources - neither academic research nor instrumentation like the DSM – despite invoking specific terminologies and making claims about the dearth of evidence on trauma in war zones. Finally, even though many of these brochures were exceedingly similar to each other, almost clone-like, they did not cite each other. Reading them, one could imagine that their unnamed authors had come up with basic notions about trauma all by themselves.

If these brochures were meant to form the basis for some kind of evidence base, particularly in an age of growing humanitarian rationalism, then they seemed rather broad and rudimentary to offer a sufficient basis to build on. Rather, each document appeared to serve as an identity card for its NGO, possibly to be used in training sessions or appended to donor reports. Still, their textual solipsism seemed curious. Why did they not cite some academic research to marshal credibility, or refer to other NGOs' brochures to show a broad knowledge of the field? And if their purpose was not necessarily to show off a scientific inclination, but rather to serve as a basis for collaboration, then why did each brochure appear to be written as though it was the only current statement available on the subject?

I asked a psychosocial project manager at Mercy Corps, a global humanitarian organization, why every psychosocial NGO seemed to have its own rudimentary “psychology 101” manual, which made no reference to hundreds of its semi-clones elsewhere in this small humanitarian field. He laughed and agreed that this was so, but explained that “NGOs are expected to produce their own documents.” Pointing by example to his own organization’s brochure about its cash-for-work programs, he explained that the brochure was not intended to be used universally or generalized to other settings. Rather, it was something that Mercy Corps

had developed that they were “comfortable with,” a stamp of their identity that would guide their workers to a distinctive mode of humanitarian response.

One of AHE’s human rights workers, Rana, expressed a similar view. When she first came to AHE after completing a master’s degree, she explained, she was surprised to see that “writing in NGOs not like in academia, where you search for gap and fill it. Here,” she explained, “all the NGOs write about similar things but with different viewpoints.” Yet while AHE and its peer NGOs did adopt clearly different policy positions or emphases with respect to asylum seekers, the distinctiveness of psychosocial NGOs was often difficult to ascertain from their exceedingly similar grey literatures. Other organizations might have similar approaches to ours, the Mercy Corps manager acknowledged, but “there’s no time to conduct extensive espionage about what the others are going and how you measure up. There’s this insularity where to a degree you focus on what you’re doing, and that’s it.”

This glut of grey literature both preceded the guidelines and persisted in their wake. It proved a challenge, however, for the IASC guidelines dissemination committee. As Robert, a guidelines co-author, put it in an interview, “It’s a significant problem. I don’t want to be unkind, but many NGOs don’t have any, you know, PhDs or people who’ve actually been involved in research, who are in a position to evaluate the nature of the evidence,” he explained. The committee did consider including all the NGO brochures and memos it could find in a collective database, Robert conceded. But this possibility was eventually discarded, as the committee did not wish, as Robert put it, to risk “proliferating mish-mash:” there was no time to screen thousands of NGOs’ training packages and assess their individual validity. The IASC reference group decided, then, on a middle road: to write and endorse one official training package and send it out into the global psychosocial sphere via dissemination sessions and lectures.

Yet the “official” version, like the guidelines, is broad and rudimentary. Like the “mish-mash” it purports to replace, exists in a similarly disconnected textual space. This version, which seems in fact to comprise a collective of multiple documents, cites only the guidelines and various uncredited “modules” and “training packets.” Credited frequently to Nancy Baron, an internationally renowned mental health consultant and practitioner holding a PhD in education with a focus on family therapy and counseling, the official version appears to have been originally called “Online Resource Kit of Training Materials and Seminar on IASC Guidelines.” However, this text has eluded my repeated searches, and its place and venue of publication is unclear. Instead, I have found numerous documents and PowerPoint presentations that appear to have been derived from it, all of them credited to Nancy Baron and bearing similar titles: “global tool kit,” “mental health and psychosocial support training,” “orientation training kit,” and so on.

One such PowerPoint presentation, given to me by Louisa, AHE’s case worker, who once attended Baron’s lecture at a United Nations High Commissioner for Refugees meeting in Tel Aviv, explains that emergencies can cause both short-term and long-term psychological impacts. Long-term impacts can in turn “threaten peace, human rights, and development.” The following slide, citing the guidelines in brief bullet points, claims that emergency victims are “resilient,” and that not all will develop psychological problems in the wake of an emergency; there are coping strategies and “protective factors” like “free cultural and spiritual practice,” which can buffer against negative psychological outcomes. The next section mentions PTSD and lists its symptoms, but cautions practitioners that most survivors will not develop it: only 3%-4% of people will develop “severe mental disorder” after an “emergency,” claims a slide that attributes this statistic to the World Health Organization, but without citing WHO publications.

I provide this example not in an effort to critique IASC's implementation aspirations, nor to make a facile critique of the silo-like writing cultures I encountered. Instead, I wish to suggest that the policy ambiguity that is seen in the IASC guidelines repeats in its dissemination package and in a glut of grey literatures that mimicked it. The IASC's various implementation toolkits cleave to the broad orientation of the guidelines: particular techniques are not mentioned, and the guidelines' agnosticism is maintained regarding which specific forms of knowledge should and should not inform humanitarian mental health interventions. As I have noted, this reflects in part a deliberate strategy – the guidelines' writing team was exceedingly interdisciplinary. But it also makes for a fascinating puzzle concerning how the guidelines might be implemented if particular treatments and methods were left most unspecified.

In the remainder of the chapter, I wish to examine two important omissions in the guidelines: debates regarding the cross-cultural applicability of psychotherapeutic methods, and the funding architecture of aid. These two topics, I argue, posed the most important concerns for my informants in the field. Practitioners were continually struggling, namely, with how to marry their own professional and theoretical commitments with the divergent needs of locals, on the one hand, and with how to carry out “sustainable” interventions on short deadlines, on the other. Neither of these challenges is mentioned in the field's most important policy document, which purports to shift practice in a new direction. Both omissions, I suggest, are important for understanding the delicate and politically fraught atmosphere of policy making in the field.

First, however, I describe one psychologist's three-week mission to Yushu, China, to work with earthquake survivors. Her experiences, I argue, capture some of the important ethical dilemmas and questions that animate psychosocial practice – a field where most interventions, however holistic or diverse, are still foreign impositions in an age where participatory, local-

driven, and holistic aid, or lip service to it, are expected. I use this practitioner's story to stage a broader review of ongoing debates about the ethics of conducting mental health-oriented aid in non-Western populations.

MENTAL HEALTH NEEDS ASSESSMENT IN A TIBETAN VILLAGE

In April of 2010, a 7.1 magnitude earthquake had struck Yushu, a Tibetan autonomous prefecture in western China, killing nearly roughly 2,700 people and injuring over 12,000. The majority of the main town's buildings were leveled, including the local hospital. Several months after the earthquake, Larena, the psychologist I have interviewed about the counseling category, flew to Yushu by herself at the behest of a large international medical NGO. She was asked to survey the local population's mental health needs for several weeks, and send back her recommendations regarding whether or not it would be worthwhile to set up a mental health program in town. The NGO she represented had an interest in setting up such a program, in part because of its desire to expand its operations into China. But she was not pressured, she said, to give a positive recommendation.

As Larena would note in her report about her three-week mission, Yushu town buildings were still mostly rubble when she arrived. As many as 100,000 people had become displaced, "living in blue government winter tents, dispersed all over the town." Buddhist nuns and monks from the local monasteries had rescued most of the wounded and buried as many of the dead as they could. With over three decades of aid experience behind her, Larena was aware that she could only learn so much about Yushu in three weeks. As she explained in one of our interviews, she was critical of NGOs that flew foreign consultants to an aid camp for two or three days to evaluate its progress, and then took the consultant's word about the project's failings

over the word of aid workers who had had toiled for months or years in the region. She did not want to be that kind of consultant.

Larena also guessed that anything to do with psychology would be read as foreign and unneeded; locals, she knew, had Buddhist monks and nuns to contextualize and support their grieving. She was careful to emphasize in our interview that she did not want her presence or her recommendations to “interfere with their religion and culture. Also in a practical sense,” she told me, “we must introduce things that they’ll be able to accept.” NGOs often rushed to give aid without respecting victims’ existing knowledge and social institutions, Larena pointed out. She considered some of them to be “cultural colonialists,” yet conceded that it was difficult “not to be one. Because you bring things they don’t have. And you bring things that you think – you don’t only *think*, in medicine for example, it’s *clear* that many times you bring good things, that save lives.”

Larena’s first encounter with local understandings of grief came within a day of her arrival. Accompanied by a translator, she approached locals in the town’s main thoroughfare and explained to them that she had come to see whether it would be helpful to bring in someone

who would go and talk to people [about] what had happened to them, and what they’re going through, to help them get stronger. Until my translators and everyone around me said, “You can’t ask questions like that.” Because with Tibetan Buddhism, you shouldn’t speak about the past. You should not speak about what had happened to you. You shouldn’t speak of the dead. Since it disrupts their path skyward. Instead you should get stronger in the words of the Buddha. To live in the here and now. To know there’s suffering, but actually to believe in it. So *my* main question was: I had no doubt there was no mental healthcare of any kind in Yushu, but there was *huge* mental support from their religion and monks. And I thought we should not introduce things that would clash with that.

Larena felt chastened by her translators’ rebukes, and ceased asking survivors to talk about their dead. Instead, she asked what they wished to talk about. Soon, she recalled, survivors of the earthquake began to speak to her of their struggle to accept their injuries and lost

homes. Family roles were reversed as former breadwinners were no longer able to work, and former caregivers now had to be cared for. As Larena explained,

I usually started an interview with the question if they can tell me what happened to them in the earthquake. Many started crying. The reaction of the translator and [NGO] personnel was, usually, that this was too intrusive and did not correspond to the Buddhist way. With time, I changed this opening question for most interviews and asked if they want to tell me something... Most people said that the religious ceremonies they are performing are their main source of support.

In her report to her supervisors, Larena recounted Yushu's healing traditions in tones that highlighted her own sense of ethnographic strangeness, and ranged from appreciation to disapproval. In Yushu, she wrote, persons who were ill were marked clearly as such by their wearing slippers instead of shoes; monks advised them to rest and be exempted from all duties. "It seems the Buddhist virtue of 'compassion' is very prevalent in practice," she remarked with admiration, noting that earthquake orphans had been readily adopted by other families. At the same time, she was not sure she approved of Tibetans' approach to grieving. As she wrote,

The local staff members who were exposed to my interventions reacted, at first, in strong rejection, saying people should not be encouraged to express their emotions of sorrow and suffering, but they need to be encouraged to overcome them and put them aside... An example was to tell a bereaved mother she should be consoled of losing her child, as there were families who lost all their children. I tried to explain the logic behind my interventions: listening to the person's subjectivity, following patient emotions as they emerged and not "educating" them, demonstrating how much these emotions came out of the patients themselves.

In recounting her efforts, Larena self-consciously emphasized her own efforts to not impose her own interpretations on survivors' own understandings of their grief. She realized, she said to me, that she was a foreigner and a newcomer to Buddhist grieving and healing traditions. One monk in her account, for example, had told her to always "listen to the person with your open heart; you have to come to the person with a pure heart." She interpreted a "pure heart" to mean having no agenda of one's own. The Buddhist way, she wrote to her supervisors,

involved “relating to the person’s body, wounds, feces etc. with acceptance and respect [such that] you don’t feel disgust or unwillingness to attend to any of the person’s needs.”

Such forms of care were exceedingly admirable, Larena reflected later in our interview. At the same time, she felt strongly that telling people not to express their sorrows was misguided: “it is not an empowering thing according to the Western canon,” she explained, and was alarmed to find high degrees of “repression” among the locals. The few who did agree to speak to her about their dead often burst into tears, letting out their grief like a flood. “When I opened the door, immediately [their grief] forced itself out,” she recalled in our interview. This put her in a difficult position:

Here I represent modern psychology, if you will, according to which repressing pain completely creates a layer of alienation and disconnection that manifests in passivity and lack of affect, something that is very fatalistic. Working through trauma is considered something that makes trauma open to negotiation with your life. This is something I believe in. And it’s something all modern psychology and its many manifestations believe in to one degree or another. And it clashes with something that I found [in Yushu] which was repression and censorship of such things, which in practice *didn’t really work*... One picture I can’t forget is of a woman whose son died. She was super-religious, walked all day with a drum and said the *om mani* religious mantra over and over. I perceived it as a technical ritual of distracting herself from what really concerned her. The only time I saw her exit that [mindset] was when people came to collect donations for the monks for the monks to go and pray... then she woke up and spoke. The rest of the time she was in a disconnected trance.

As she described the local population’s apparent propensity for grieving in silence, Larena drew alternately upon two different idioms or repertoires. In the first idiom, she spoke of this practice matter-of-factly as bordering on an injustice to the population by not letting them cope or “work through” their grief. Yet in the second, she self-consciously placed her own view within the context of the *psy* disciplines, acknowledging that she probably felt this way due to her own training, and specifically, the significance in psychoanalytic theory of talk and self-disclosure (Furedi, 2003). Repeating *om mani* over and over, Larena said, would not count

according to her own discipline as being self-aware, and would therefore not be considered a healing act. In her written report, however, she was careful not to say this outright; instead, she precariously straddled the two idioms:

Most of the population repeat incessantly a phrase that consists of six Tibetan letters that represent a praying: *om mani pad me hum*. It is done in a quiet humming way, accompanying all other talk or activity the person is doing. In trying to understand it, I think of a psychological mechanism in which part of the inner world of a person is disconnected from the immediate reality and is secured by the repetition of sanctity.

Larena seemed keen to understand the meaning that locals invested in prayer. However, hints of her own skepticism emerged periodically in terms like “incessantly.” The local monks, she acknowledged in our interviews and in her report, had given enormous support to the local community, but the manner in which it manifested, she feared, prevented locals from engaging *personally* with their suffering. The woman repeating *om mani*, for example, had seemed to Larena to be disconnected from her own pain.

For example, Larena described a visit to a Yushu school in which about thirty students, or ten percent of the student population, had lost their parents in the earthquake. These orphaned children behaved differently than the others, one monk had told Larena. When she inquired as to how, she wrote afterward, he gave her “a classic description of PTSD symptoms: they are very sensitive, they cry more easily.” They also had nightmares and they did not sleep well. She continued probing him:

When I ask [the monk] what he and the other teachers do to help these children, he says they are giving them more attention and they console them more: they compare the child with others who lost more and make him see what he does have. The main consolation is: you have the future ahead of you – be strong; the knowledge of Buddha will make you strong again; knowledge and studies will help you. He feels this help is useful and sees the children coping better with their problems already, since the school has started. When I speak about PTSD and our knowledge in helping these victims, the monk says that the Tibetan people do not need help from outside.

This excerpt demonstrates again her tonal ambivalence. Larena is careful to show respect for the monk's focus on the positive and on the future; she does not marvel at the locals' ignorance of PTSD, nor does she explicitly fault the absence of treatments targeting trauma in ways with which she is familiar. But she still attempts to persuade the monk of the utility of these techniques, out of a belief that talking through one's grief is vital. As she recounted to me in a subsequent interview,

They go to ceremonies where they can fast for 40 days or eat very little and pray all day. It's a part of working through death. But it's a collectivistic form of working through which stabilizes yet doesn't open, and doesn't allow for the dialogue we think of in psychology that enables a person to express his pain and grief and share it personally with others. And to remember and give space to many individual things, without the mediation of someone else and [without consisting only of] prayers that are organized with words that you must know in advance.

Larena went on to argue that repeating prayers by rote did not constitute a genuine engagement with one's grief. When I recounted Larena's story to a Canadian aid worker and researcher working in Pakistan, she immediately replied that some of her fellow expatriate aid workers themselves had said, "Islam does nothing for these people," without attempting to understand the forms of healing that locals derived from Islamic practice and worship. Larena, I suggest, was not nearly as glib or hasty in her judgments. Indeed, she came across as a particularly self-deprecating practitioner who kept reminding herself of her own professional lens and how it might be prejudicing her against other forms of knowledge. Yet her professional toolkit and experience placed certain limits upon how she felt she could intervene in this setting. Her understandings were bound to clash with locals' unless she completely discarded talk therapy.

Larena's concluding notes on future humanitarian action in Yushu were ambivalent. She did recommend a psychosocial mission, but was careful not to emphasize trauma. Any

practitioner who succeeded her, she wrote, had to be made thoroughly aware of the Tibetan belief system:

In view of the specific beliefs and practices of the Tibetan population that are not compatible with psychotherapy as we use it (concerning the Dead and the avoidance of expressing difficult emotions), I think we should not offer a general mental health intervention in relation to the traumatic earthquake. Rather, we should offer interventions that are focused on concrete difficulties in dealing with everyday life. It means more reality-oriented psychotherapeutic techniques. Once inside the therapeutic process, we might work through the traumas, with certain patients who wish it, by a more psychodynamic approach.

Larena's efforts to be circumspect about psychotherapeutic techniques reveal the kind of bind in which reflexive aid practitioners in a postcolonial era often found themselves: she did not want to impose, or be seen as imposing, foreign knowledge upon survivors who relied strongly on local monks and religious rituals to structure and help them make sense of their grieving and healing. Her reference to "reality-oriented" techniques, even with the word "psychotherapeutic" thrown in, deliberately connoted an exceedingly wide array of activities, which could include anything from talk therapy and economic assistance to suggestions on how to get around the rubble-strewn town in a wheelchair.

The phrase "reality-oriented" was part of a growing lexicon of terms that post-guidelines practitioners have used to differentiate themselves from trauma-focused parachuters. Yet, perhaps in deference to her supervisors' expectations, Larena did briefly acknowledge the possibility of trauma-oriented work with those "who wish it." Her own view on the suitability of such work in Yushu thus remained somewhat inscrutable, utilizing neither idiom 1 nor idiom 2 in any clear way. In our interviews, in contrast, she tended to draw alternately on two distinct repertoires (Gilbert & Mulkay, 1984): a defensive stance and a critical stance towards psychotherapy.

OMISSION 1: MENTAL HEALTH PARTICULARISM AND UNIVERSALISM

In his 1997 article titled “Tensions in the Psychosocial Discourse,” Alastair Ager places such vacillation in broader context. The most important question of his field is “whether psychosocial programmes adopting a broadly clinical approach have any justifiable role in addressing the needs of populations facing the consequences of conflict” (p. 402). For critics like Derek Summerfield, Ager continues, the answer is a resolute no: since the context of such settings is nothing short of the “destruction of the social fabric,” rehabilitation should focus on “the reconstruction of social forms,” and not on individual treatment (ibid). Yet other practitioners, Ager notes, do see an important role for clinical interventions in such settings.

At stake in such bifurcation, Ager argues, are three tensions: “the generalizability versus uniqueness of relevant knowledge, the valuing of technical versus indigenous understandings, and the planning of targeted versus community-based interventions” (1997, p. 402). With respect to the first, he writes, some actors believe that given the vast historical and cultural differences among populations, psychotherapy and related methods should play little to no role in non-Western aid contexts. Others, however, believe that “core psychological functioning is broadly invariant across cultures” (ibid.).

Some of the practitioners I interviewed, particularly those who did broad, community oriented work, sided with the former view. But a few openly sided with the latter view, suggesting that mental illnesses were largely similar across cultures while their manner of presentation differed. As one UK-based psychiatrist and researcher who served as a frequent WHO and UN consultant on mental health policy matters said,

I think illness is fundamentally not different in different countries. Fundamentally, you find depression, anxiety, psychosis, occasionally PTSD, and epilepsy in every country, all right? And it’s the same illness, it’s not a different illness. However, there are cultural differences in the way people complain about their illness, and the way they present to

services, and the way the community manages illness... So you're right that cultural things matter, but they don't matter in the way you might think they do, in that it's not to say that depression doesn't exist in Afghanistan, it does, you know. Psychosis exists there. But what they might have complained to you about, as the health worker, might be different. *There* the family might bring a woman in and say "she's thinking too much." Here, the family wouldn't bring them in. The person would go themselves and say "I'm depressed, I'm crying."

Questions regarding and variability of mental phenomena across cultures are not unique to humanitarian mental health: the field of cross-cultural psychology has an extensive literature on the subject.³⁶ Yet these questions are omitted from the guidelines, perhaps in deference to the interdisciplinarity of the writing team and to the fact that many of the authors did not see themselves as psychologists or psychotherapists. This omission, I suggest, fails to acknowledge important debates in the field regarding how sustainability – one of the guidelines' core goals – might be defined or achieved.

For example, a growing global group of primarily American and European researchers and practitioners have identified with what they call the Movement for Global Mental Health (MGMH). Mental healthcare in most low and middle income countries, they argue, has scarcely advanced beyond asylums and inpatient models, which place patients in decrepit and crowded while leaving millions of others unattended (see review by Campbell and Burgess, 2012). The movement calls to reduce the mental health "treatment gap" in these countries by "scaling up" treatments and integrating them into preventative care systems. Western governments, MGMH proponents argue, should devote more resources to such endeavors, instead of continue to bankroll short-term interventions that leave little long-lasting impact.

Among my informants, several psychologists and psychiatrists were supportive of MGMH. They lamented what they said was an all-too-typical aid scenario: a disaster or a war

³⁶ See, for example, Shiraev, E., & Levy, D. (2006). *Cross-cultural psychology: Critical thinking and contemporary applications* (3rd ed.). Boston: Allyn & Bacon.

breaks out in a low or middle income country, and donor funding suddenly pours into a neglected region. But these funds are as fickle, and can only rarely be made to support long-term projects that like building mental health centers, training practitioners, and reforming health policies in developing countries. Instead, MGMH advocates nearly always fight losing battles with their better-funded relief-oriented counterparts. As one psychiatrist put it,

All the money after a crisis tends to go to these humanitarian agencies, for reasons best known to the donors. They do it because they feel that the [local] government isn't in a state to handle the money, because it's fighting a war or whatever. But they know they can get good reporting back from the humanitarian agencies. The humanitarian agencies are expert at saying, '1,001 people were treated yesterday in the following way.' So [donor countries] get fantastic reporting, they can show their taxpayers that the money has been well-spent. But in terms of the overall long-term impact for the country, it is not being well-spent.

MGMH proponents have accused relief-oriented practitioners and NGOs of poaching local practitioners from longer-term development projects that could not pay as much. In a personal correspondence, Robert, the guidelines co-author, who is not affiliated with the MGMH, nevertheless agreed with this contention:

The poaching issue is very real. As I mentioned, in Sri Lanka, people said that early in the tsunami (even in conflict areas), people initially helped each other. Yet once the NGOs came and monetized everything, natural helping rapidly declined, as local people started asking 'how much will you pay me'? Also, the poaching sucked the best natural sources of psychosocial support out of the communities--psychosocial workers went to work in NGOs and rode in fancy cars, pulling them apart from their roots. The sad irony is that most NGOs had their funding dry up and have either folded or are currently living on the brink. A lot of harm has been done in this way.

Several of my informants objected to the implication that all short-term interventions were harmful. Some interventions with short horizons, like cash-for-work programs, they argued, could support and complement longer-term projects. However, the MGMH proponents I spoke with were generally skeptical of this claim. A UK psychiatrist said that while some short-term interventions were surely helpful, there was no global agreement among donors to make

sure long-term projects were not neglected in favor of media-grabbing crises: “The donors are not thinking ‘well, let’s give 50% of our money to long-term development and 50% to the short term’,” she argued. Rather, “They just think, ‘We’ve got to be seen to be doing something. There’s a humanitarian crisis, it’s easy to disperse this money to the humanitarian NGOs, we get good reports back, problem done’.”

At first glance, I suggest, the MGMH appears to favor a rather broad and unexceptional holism mandate, calling for long-term interventions that targeted communities and helped bring treatment to those who lacked access to it. However, what is it that the movement has sought to “scale up”? critics have asked. Is it still to consist of biomedical, psychiatric, or psychotherapeutic theories and treatments, or broader conceptualizations of care?

A special issue in the journal *Transcultural Psychiatry*, edited by Catherine Campbell and Rochelle Burgess (2012), brings many of these questions to light. The global mental health movement, they argue, often leaves the word “treatment” nonspecific; its vision of assistance, Campbell and Burgess argue, still lies “within universalized western understandings of health, healing, and personhood” (p. 379). There are numerous indications, they claim, that the ideology of care driving the MGMH still conceives of mental illness in individual, not social, terms, and local healers and practitioners whose knowledge is nominally praised are in practice treated as “handmaidens of biomedical expertise” (p. 381).

One of my informants, a mental health director in a prominent international NGO, was quick to take issue with this critique. While he did not affiliate with the MGMH per se, he said, he wished to defend it on one point: “a lot of academics have spoken out against global mental health as the imposition of Western concepts, as though biomedical services were not already being delivered,” he noted. “They *were* already being delivered, but poorly.” Critics of the

MGMH who feared that local knowledge would be neglected, he argued, often forgot that in most developing countries, “local” knowledge and healing were already thoroughly cosmopolitan, having already been repeatedly touched and altered by Western biomedicine.

In parts of India and Pakistan where he had worked, for example, psychopharmacology had been the norm for decades among local practitioners. Often, however, this was more for structural reasons than because of lack of other training: “many [local] practitioners were trained in psychoanalysis, but all they have the resources to treat with is pills,” he said in frustration. Rory, the psychologist who led a psychosocial mission in Palestine, shared a similar story regarding his efforts to get local medical practitioners to *stop* giving so many pills to patients. As Rory put it in a tongue-in-cheek tone, “mental health becomes a pharmacy in these contexts.” His semi-serious tone notwithstanding, I had heard the same claim from other expatriates commenting on mental health systems in developing countries. In Saiba Varma’s (2013) account of mental healthcare in Kashmir, moreover, it was typically foreign NGOs that tried to persuade local practitioners to move beyond the pharmacological model, not the other way around, unlike what some critics of the MGMH have assumed.

I have brought up the MGMH debate in order to make two points. First, notions of sustainability, holism, and locally driven interventions – to which the 2007 guidelines often allude as positive and desirable – are not objectively specifiable, but interpretatively flexible. While some practitioners see short-term relief as necessarily coming at the expense of long-term development work, others argue that relief continues to play a vital role in long-term agendas. As another example, while MGMH proponents insisted that low-income countries needed scaled-up mental health programs that focused on awareness and prevention rather than the

institutionalization of patients, others argued that such modes of care occasionally drew upon a narrow biomedical model that posed a threat to local healing traditions.

Second, notions of holism, sustainability, and participatory aid have often been conflated in psychosocial discourse, or at least, taken for granted as being mutually constitutive and complementary. However, in practice, various manifestations of one notion have clashed with those of another. For example, as Ager (1997) notes, interventions that are purported to be longer-lasting are not necessarily those that value indigenous understandings. Moreover, visions of care that explicitly strive to value such understandings have sometimes relied upon misguided notions of what local knowledge looked like, as the pharmacology examples indicated.

Meanwhile, I argue, the guidelines omit any reference to such conflicts or debates, presenting a decidedly simple view that that striving for sustainability and striving for locally driven aid are part of the same mission. As this section has shown, the reality is more complex than that: sustainability and holism, like “participation,” belong to a “pantheon of development buzzwords, catchphrases and euphemisms” that can be, and have been, attached to diverse and even contradictory referents (Leal, 2007, p. 539).

More broadly, I argue, the guidelines’ omission of debates about the cross-cultural applicability of psychotherapy obscures the fact that different worlds of knowledge are irreducibly pitted against each other in aid settings, and particularly so when psychotherapy is the main tool of intervention. The sensitive postcolonial encounters that often unfold in aid settings, as Larena’s example in Yushu illustrated, are absent from the world of aid that the guidelines envision. In the final section of this chapter, I describe another omission in the guidelines: the effects of aid funding on daily practice. The ways in which funding is parceled, I

argue, strains relationships among NGOs and poses additional challenges to sustainability and coordination.

OMISSION 2: SHORT-TERM AID FUNDING

The 2007 IASC guidelines insist almost reflexively upon sustainable, community-wide interventions. Nowhere do they mention an increasingly onerous barrier to sustainability in frontline aid practice: short-term funding by donors. In a conversation with a logistician working in the West Bank for Medicines du Monde, she noted that donors typically funded psychosocial projects in the region for increments of 3 months or 6 months, or, if lucky, a year. In such a short time, she said, it was easier to recycle short-term projects that temporary volunteers with little local experience could run, like psychosocial camps for children, than to attempt to build a community mental health center in Hebron and recruit and train its staff.

Over the past few decades, donors have increasingly parceled out aid monies in short-term contracts (Barnett & Weiss, 2008; Cooley & Ron, 2002). These developments, critics have noted, have caused a sea change in the aid sphere, encouraging brief interventions with rapidly calculable gains at the expense of slower-burning projects that might not yield quick or visible results. An OXFAM briefing report (Ahmad, 2011) suggests that donor countries are less interested in long-term effects because they are rarely held accountable for them: “Domestic audiences [in the global north] are typically happy to know that their aid built schools, but do not always ask questions about how those schools raised the level of education in a country” (p. 12).

This point may seem compelling, but funding cycles depend on a more complex interplay of donor countries’ foreign and domestic policies alike (Hofmann et al., 2004). As Prato (2006) puts it, “donor governments increasingly try to hide their policies behind complicated application processes that claim to reach objective decisions” (p. 13). In practice, however, Ian Smillie and

Larry Minear (2003) suggest, “donor behavior” is best understood as a “patchwork of policies [that] do not provide a coherent or effective system for financing the international humanitarian enterprise” (p. 1).

I often asked my informants how they coped with short-term grants. One British aid scholar spoke proudly of a literacy project that his friend had been able to keep running in Kathmandu for 10 years, mainly by migrating from one grant to the next and tweaking his project description slightly each time. Stories like these, however, seemed to be the exception. One startling outcome of the humanitarian funding structure has been that the political economy of aid chafes not only against aid’s growing rhetoric of sustainability, I argue, but also against the aid industry’s increasing efforts to extract from NGOs more precise, evidence-based interventions (which intuitively, short-term funding might be expected to encourage). Short-term funding, in other words, has increasingly left aid workers scrambling to act quickly in ways that aid actors both in the front lines and in NGO headquarters would consider neither “sustainable” nor “rational” (e.g., systematic, evidence-driven, or efficient). Below, I support this argument by describing how competition for aid funding has tended to unfold.

As aid scholars Alexander Cooley and James Ron (2002) have noted, competition, not cooperation, dominates aid relationships. NGOs compete with one another for funding contracts that are typically “performance based, renewable, and short term” (p. 7). Because the availability of grants is often uncertain, aid workers experience enormous pressure to concern themselves with organizational survival. “Competition has an upside,” concedes Stefano Prato, managing director of the Society for International Development, “which includes greater attention to results, economies of scale, [and the] ability to specialize and globalize” (2006, p. 29). However, he notes, grants are often divided into timespans so brief and incompatible with

how long most interventions take that NGOs find it difficult to comply with them.³⁷ As a result, NGOs increasingly prefer interventions that can be made to show results quickly, and these – for example, day camps – tend to leave fewer lasting traces.

As Cooley and Ron note, short-term funding discourages collaboration. NGOs rarely have the time to carefully study what their competitors are doing or to offer to collaborate – supporting the Mercy Corps psychosocial manager’s point about why clone-like grey literatures exist. For this reason, NGOs are also more likely to implement interventions that are redundant or that fail to fill necessary gaps in aid. As Robert, the mental health researcher and consultant, put it,

If I’m working for [a large international NGO], and I want my programs to be funded, the last thing I would do is collaborate. I would go out, collect assessment data, position myself close to the donor, convince them that, you know, I’ve got this information and analysis, we’ve got this capacity that other agencies don’t have, here’s our comparative advantage. It’s really about planting your flag and competing. I hate to say this, but it’s really effective in generating high levels of competition. It’s really adverse to collaboration.

Eager to be seen in emergency settings (Calhoun, 2010), NGOs engage regularly in turf wars over high-profile disasters and conflicts, often rushing to “poach” local NGO staff and even aid recipients from competing NGOs (Stirrat, 2006). Donors’ expectations of high efficacy and low tolerance of failure, moreover, encourage NGOs to lie about failures and inflate successes.³⁸ Such pressures complicate the industry’s efforts to maintain transparency and cultivate a culture of learning from mistakes and of genuine striving for improvement. As Prato (2006, p. 12) puts it,

³⁷ This is somewhat different for development funding, although the line between humanitarian and development work is increasingly blurring.

³⁸ This is not always the case. An aid worker and researcher working in Pakistan once noted in a personal correspondence that sometimes NGOs strove to fail, knowing that some failures would simply result in a new funding cycle, whereas successes could cause a project to be deemed “done” and thus cost people their jobs. “Many times,” she wrote, “the tension between needing to ‘succeed’ (so as to suit funding dictates) and needing to ‘fail’ (if only to sustain elite-level non-governmental bureaucracies) was an overt aspect of the development process.”

NGOs are often expected to ensure a 100 per cent success rate. No business community would ever hold such an expectation when investing in new ventures. Such an expectation of success leads inevitably to falsity. NGOs are often unable to tell the 'real story' of their initiatives, to report what really succeeded or failed, to reflect upon and discuss openly about what worked or what did not. They are obliged to report endlessly their claims for success. This 'pretence' does not promote real knowledge sharing and learning within the broader development community.

NGOs get caught up in this performance, Cooley and Ron (2002) argue, not because their motives are inherently opportunistic, selfish or suspect, but because they have no choice. Such constraints, unsurprisingly, tend to undermine sustainability goals: "Institutional imperatives emphasize competition, short-term results, hierarchy, secrecy and a Northern bias, whereas development imperatives generally demand the opposite: coordination, longer term results, partnership, transparency and a Southern bias" (Biekart, 1999, cited in Hootsmans, 2008, p. 18). In sum, however sustainability-minded NGOs might claim or wish to be, their funding conditions often leave them no choice but to spend considerable time on organizational survival, at the expense of cooperation with other NGOs or painstaking ground-up work with aid recipients.

This double-bind is widely recognized by aid workers and scholars, but is rarely formally addressed by donor governments or agencies. A go-to argument in favor of existing funding mechanisms is that competitive, performance-based funding ensures that only the most efficacious and high-quality aid projects are funded (Cooley & Ron, 2002). But echoing Stein's (2008) discussion of aid dependency, "efficiency" and "quality" have no uncontested referents: they can be redefined in any manner that appears to legitimize performance-based funding. Another difficulty is that donors increasingly earmark funds for specific aid projects, and are disinclined to fund administrative overhead or staff salaries. Donors maintain this helps to reduce waste and administrative bloat; however, it also leaves NGOs scrambling to maintain

their organizational identity and memory. For NGOs, Smillie and Minear (2003) argue, “maintaining capacities from one emergency to the next, reinforcing an agency’s identity, covering overheads, and meeting their own priorities represents [sic] a complex and difficult management problem” (p. 30).

I was eager to explore the consequences of short-term funding for NGOs’ institutional memory. Milena, an American psychosocial aid worker working in Pakistan, noted that mental health practitioners were typically contracted to work or volunteer for short-term stints. When they arrived on site, she said, they had to begin work immediately, having little time to read prior reports or learn the recent history of the organization or its constituents. For this reason, she added, many would unwittingly “try to re-invent wheels,” frustrating local NGO staff who had been with the organization longer and could remember previous expatriates’ nearly identical projects. With a smile, Milena recalled having herself been hired twice by the same NGO to do the same intervention she had done for them five years previously, in much the same manner and with the same constituents. Those who hired her had no idea she had already worked for them in the same capacity: the staff had completely turned over in those years. It was ironic, she agreed, that in an industry so preoccupied with reporting, there was frequently such a dearth of institutional memory.

Another compelling example came from Haiti. Rina, an Israeli psychosocial aid worker with training in education and disaster management, traveled with an international NGO to Port-au-Prince several weeks after the earthquake, intending to work with displaced and orphaned children. When she arrived, she recalled in an interview two years later, hundreds of NGOs were already on site, scrambling to lay a claim to a piece of the aid scene. “When a new organization comes to a crowded intervention site, you’re not going to sit around looking at what other

organizations are doing or asking to join them. There's no time for that," she explained. Instead, she and her colleagues had approached the head of each displaced persons camp and asked where the local schools were. "And then we'd start our work," she explained. "In general, an organization arrives on site not to collaborate but to do their own thing." The result, she added, was classic "parachuting" chaos: a blend of redundancy, gaps in aid, and a lack of information about what was being done and where.

However, Rina went on, it was not the commonly faulted vagueness of psychosocial aid that caused such chaos, not the variable amount of training that aid workers possessed. Rather, she claimed, it was the more mundane insufficiency of aid oversight and monitoring in the region. "In the aid world in general, and extremely so in Haiti," she said, "they don't check [what you do]. There's a lot of money, but not enough enforcement of reporting and transparency." She gave an example: "it was possible for us to write down things that never happened, and no one would know. For example, [we could say] that we went into the camps every single day, when in reality we did not."

The "dependency relationships" that emerge between NGOs and their donors, Stefano Prato notes, "limit the capacity of NGOs to be active and express themselves freely in important political spaces" (2006, p. 11). The occupied Palestinian territories present an important example. Jeremy Wildeman (2012), an aid worker who spent a decade working for NGOs in the West Bank, has argued that most international donors do not wish to be perceived as intervening directly in the conflict, or as supporting interventions that are explicitly critical of Israel. As a result, NGOs dependent on foreign funds have had to avoid engaging in anything that looked political. Instead, many have resorted to "donor-safe" interventions that explored broad themes as peace, co-existence, and dialogue among two Israelis and Palestinians, unintentionally lending

credence to an increasingly counter-factual myth that there is still a dialogue relationship or peace process among the two sides to the conflict. Frontline aid workers and Palestinian civilians alike realize that they are engaging in an aid theatre, Wildeman (2012) writes, but must generally keep such criticisms to themselves unless they wish to lose an important percentage of their funding. This example recalls important critiques of humanitarian assistance as interfering with or coming at the expense of political action (Feldman, 2009).

Larena, the psychologist who had gone to Yushu, has also worked for decades in the West Bank. She described a similar dependency among the foreign and local staff of the same aid organizations. According to her, Palestinian staff of international NGOs typically “receive a salary that relative to Palestinian salaries is very high. It creates a huge dependence in that [local staff] won’t dare to critique [their employers] because tomorrow they can tell them to leave. Their contract is a temporary contract.” Several local counselors had confided in Larena that foreign NGOs, despite making an elaborate show of soliciting their opinions, did not genuinely take those opinions into account. “They do consult them,” Larena explained, “But the locals’ feeling is that they don’t *listen* to them. If you went and said this to [the NGO], they’d say, ‘of course not, of course we ask them.’ But the decision doesn’t come from field people, but from management people.”

During the Second Intifada in the early 2000s, for example, local waves of violence prompted an international NGO running a West Bank mission to create a security scale for its foreign and local employees. Every day, the security level was assessed and directives to staff were given accordingly. However, Larena noted, security levels did not always line up with how safe local staff felt. For example, one missive from the Jerusalem branch of the NGO had stated, “today it’s dangerous to go outside because there was an IDF raid, so don’t come to work today.

Stay in the office.” Locals responded, “but we live here. We know what happens. Why don’t they listen to us, to how we assess the situation?” In other cases, the opposite happened: “how could they force us to go out and stand in front of IDF guns when we, who are on the scene, tell them it’s dangerous?” several local counselors told Larena. The violence of settlers towards Palestinian civilians, for example, was typically discounted by the Jerusalem office, they explained.

The fact that the guidelines do not mention funding constraints is, from one perspective, quite understandable: they are intended as a broad endorsement a particular approach to humanitarian mental health, not as a nuanced critique of barriers to its actualization. The document aims to outlive its era: as funding climates change over time and vary from setting to setting, it would make little sense to address what might be transient or local impediments to sustainability in a document that strives for global, long-lasting applicability. One could argue, for example, that such an omission is not an indication that the authors were not aware of these barriers, but that they did not consider it helpful to address them in this particular venue. Nevertheless, this omission creates the impression that whether or not aid makes a long-term impact falls entirely to the competence or will of individual aid workers. Important systemic factors, like funding, are obscured, amounting, I suggest, to a form of depoliticization (Ferguson, 1990).

In 2011, the IASC published a second set of guidelines for the evaluation of psychosocial interventions (Ager et al., 2011). Co-written by Alastair Ager, who had written persuasively of the tensions underlying the psychosocial discourse (1997), these guidelines were officially endorsed by UNICEF, Doctors of the World, and Save the Children, among many other prominent international NGOs (Ager et al., 2011). The guidelines teach users how to sample,

measure and quantify psychosocial concepts and behaviors, and more specifically, how to operationalize psychosocial well-being. Proposed measures include a “reduction in troubling dreams” and “increasing collaborative behavior with teachers and peers” (p.7).

Like the 2007 guidelines for mental health, the 2011 evaluation guidelines make broad references to the persistent ambiguity of psychosocial aid, and in particular, to the need for “appropriate quantitative tools for assessing psychosocial well-being” (p. 6). Despite “the complexity of the linkage between psychosocial issues and other aspects of well-being,” the guidelines state, practitioners “should not allow so broad a definition of psychosocial work that it is meaningless” for evaluation purposes (p. 24). Like the 2007 guidelines, the 2011 document is notable for its lack of reference to funding constraints. Yet this absence takes a different form: instead of merely leaving out notions of funding, the document openly tells practitioners that “committing resources to evaluation is an essential part of good programming,” even though they tend to have no decision-making capabilities with respect to resource allocation. Such statements, I suggest, perpetuate the view that funding decisions simply unfold in lockstep with what planners deem a “good idea,” or with what is considered “rational” or “effective.” By reducing resource allocation for psychosocial evaluations to questions of rigor, and entrusting it to a nondescript imagined aid worker, the guidelines thereby erase common disagreements among donors and NGOs regarding which interventions are most worthy of funding, and regarding how to estimate the value of what has been funded.

Overall, I have argued in this chapter that the guidelines make for an inscrutable read: written primarily as broad exhortations of holism, participatory aid, rigor, sustainability, they are difficult to use as a practical field guide. Their ambiguity, I have suggested, persists curiously in various auxiliary documents (e.g., van Ommeren, 2005) and in guidelines dissemination tools, as

well as in the clone-like grey literatures of psychosocial NGOs. Instead of detailed discussions of particular techniques or hypothetical frontline vignettes followed by specific discussions of what would or would not be helpful to for a practitioner to do in each, these documents stick to more general directives: work for sustainable goals, do not assume that disaster victims are uniformly traumatized, and conduct rigorous assessments of local need.

The guidelines discourse thus reflects and reinforces the vagueness of the psychosocial category itself, which, as I have described with respect to the term “counseling,” may result in unexpected difficulties in the field. For example, the interpretative flexibility of “psychosocial” and of “counseling” has permitted frontliners to quietly hire local practitioners whose work was deemed highly valuable even if they lacked official credentials – a good example of loose coupling (Orton & Weick, 1990) and frontline discretion at work (Lipsky, 1980). At the same time, such vagueness has also periodically been equated with a lack of expertise and exploited as a convenient excuse to deny local counselors higher training.

Notwithstanding their generality, the guidelines still serve an important symbolic purpose, as Aline had intimated at the beginning of this chapter: to disassociate “respectable” practitioners from the parachuting archetype and its hubris-laden connotations of individual treatment being given to aid recipients whose needs are more general and systematic. The guidelines also serve a different mandate – to gesture broadly towards the need for greater evidence-based and rigorous aid, although, as I suggested in chapter 3, notions of rigor and evidence remain hazy in both the guidelines and in the field at large. Such dual mandates, I have suggested, have tended to clash in their respective visions of what humanitarian mental health should strive to achieve.

The guidelines, I suggest, omit the most important challenges of frontline practice: for example, how are practitioners with psychotherapeutic training to adapt their methods locally? How are they, as Larena's example showed, to persuade locals to articulate their grief verbally when such expectations collide with local practices? Moreover, how are practitioners to overcome the practical limitations of short-term funding? The absence of funding constraints from the guidelines and from subsequent policy documents (Ager et al., 2011), I have suggested, constitutes a depoliticizing move that reinforces the rationalization paradigm's view of aid as hinging merely on the skills and ethics of practitioners themselves, rather than on wider political decisions over which they have little to no control.

The breadth of the guidelines, I have argued, likely reflects a choice on the part of an interdisciplinary writing team to avoid prescribing specific methodologies that would not fit certain aid contexts. The writing team, I suggest, likely possessed a nuanced view of frontline practice as contextually variable, and of policy itself as contested and negotiable; many of its authors, after all, were once practitioners themselves. This idea would fall in line with David Mosse's (2004) and Richard Lipsky's (1980) notion of practice being largely context-driven rather than closely dictated by predetermined policies.

Thinking back to AHE's frontline aid indeterminacy in chapters 1 and 2, and to AHE's executive director Tom's seeming tolerance of it, however, an important question still remains: could we conclude, based on the breadth of the field's white papers and dissemination tools, that the guidelines writing team shared some of Tom's managerial philosophy? In other words, could these policy makers have cleaved to generalities in their policy briefs because they realized that trying to micromanage such a diverse field of practice would be inappropriate or impossible? Or might they have attempted to reconcile the necessity of producing a guidelines "deliverable"

with a product that could still account for frontline indeterminacy? Do what extent, then, we may ask, did they view policy as a “relational, contested, and never-finished process” (Eyben, 2011, p. 20)? Or alternatively, could the guidelines simply have represented a ceremonial front to a larger and more complex policy-making initiative, regarding which any inferences about anti-rationalization at the policymaking level would be premature?

This question would be impossible to tackle without, at minimum, a closer study of the guidelines’ implementation on the ground, which exceeds the scope of this dissertation and would perhaps be, at this early stage, somewhat premature.³⁹ Yet I would like to briefly consider the two possibilities I have listed above. The “reflexive policymaker” possibility, I suggest, is supported by scholars like Emery Roe (1991), who has argued that rural development actors do realize, at least to a larger extent than is commonly assumed, that premade plans and blueprints for development tend to fail in practice. Such awareness rarely precedes or follows dramatic crises of faith in aid rationalization. Rather, it is usually a more mundane, level-headed recognition that projects in unstable and uncertain environments require flexible, not rigid policies in order to “work”.

Admittedly, Roe (1991) notes, not all aid actors arrive at such realizations easily: blueprints for development do tend to be jealously guarded as comforting simplifications even in the face of repeated failures to implement them. At the same time, while reviewing an array of rural development projects, Roe notes that development managers in the field tend to behave as though they have long taken the necessity of loose coupling for granted, understanding that

³⁹ One informant, the mental health director of a large NGO, argued that the guidelines would take “years” to change the field and that it was premature to draw conclusions about their efficacy. He likewise was not surprised to hear that virtually none of the frontline practitioners with whom I spoke had heard of the guidelines. “Why *would* they have heard of them?” he mused, implying that the guidelines were more the concern of NGO headquarters.

development projects need to contain a certain amount of “slack” so that the inevitable delays and unexpected turns would not derail them (1991, p. 293).

The same sort of “loose coupling work” could have been happening while the 2007 IASC guidelines were being written. This would imply that these aid actors were writing policy “loosely” on purpose – a possibility that, if true, would call for a re-evaluation of aid rationalization in the field. At the same time, Evelyn Brodtkin’s (2008) brilliant description of policy-making in U.S. legislative contexts implies that the challenges of real-life law-making turn on many moving parts, and not merely some reflexive policymakers. As Brodtkin (2008, p. 320) notes,

Analyses of legislative policymaking revealed how, in a decentralized, two-party state it is strategic to oversimplify problems, overstate solutions, and mask competing objectives in order to build a legislative majority. Unfortunately, successful coalition-building strategies often produce policies better geared to political credit-claiming and blame-avoiding than to successful implementation. Those policies that survive the legislative fray tend to be creatures of compromise in which policy inconsistencies, ambiguities, and silences constitute a necessary price for passage... it becomes apparent that implementation difficulties emerge, in part, out of the dilemmas of policymaking.

As Brodtkin argues, the qualities that often make policies easier to pass – keeping mum on controversial issues and making wide promises – are also those that make them harder to implement. This phenomenon, she argues, implies a problem for democracy. Her insight, I suggest, can be applied widely beyond the U.S. legislative context. Yet if the 2007 guidelines’ ambiguities and lacunae, on this reading, are but the “necessary price for passage” for a policy document that aims to be as widely applicable as possible, then it might be overreaching to suggest that the guidelines represent “loose coupling reflexivity” at the highest echelons, or that policymakers themselves embraced indeterminacy in the front lines of humanitarianism. Instead, they may have simply aimed at a wide audience, and unintentionally ended up appearing to

embrace frontline indeterminacy, as well. If this is true, then what role do aid rationalization efforts play in the psychosocial field? In the final chapter of the dissertation, I will examine how aid actors measure the efficacy of psychosocial interventions, and how the limits of rationalization are understood and communicated among aid actors.

CHAPTER 5

LOGFRAMES AND INDICATORS

The language of humanitarian assistance, Janice Stein (2008) observes, has increasingly included terms like benchmarks, outcomes, impacts, and outputs. These paint frontline practice as a machine-like march, or an “exercise in instrumental rationality” (2008, p. 126). But appearances can be deceiving: “Does the new language layer over deeply entrenched norms and practices with only marginal changes in practice,” Stein asks, “or has this language penetrated deeply to enable substantive change?” (2008, p. 125). This final chapter addresses this question by considering the capacity of managerial practices to producing governable, auditable subjects in the humanitarian sphere (Barnett, 2005; Paul, 2015).

I begin by describing one aid worker’s critique of psychosocial evaluation, which illustrates some of the limits of aid rationalization⁴⁰ by drawing attention to aid impacts that cannot be measured. I then introduce the logical framework (logframe), a quantitative tool for monitoring and planning interventions. Describing the challenges aid actors face in translating aid work into logframe models, I ask how logframes, and humanitarian managerialism more broadly, seek to make frontline practices auditable. Finally, drawing on ethnographic examples, I suggest that donors and frontline aid workers alike are aware of the limitations of logframes.

⁴⁰ The term “rationalization” carries both descriptive and normative weight, and my uses of it are meant to underscore the laudatory flavor that the term is often given in aid contexts. In his essay on the social and moral thought of Max Weber, whose writings on bureaucratic rationalization are an important precursor for current rationalization discourses, Rogers Brubaker (1984) counts more than 16 distinct meanings of “rational” in Weber’s body of work, which include: systematic, calculable, rule-governed, predictable, efficacious, consistent, quantitative, methodical, sober, and scrupulous. The interpretive richness of the term is no accident: “Rationalization for Weber,” argues Brubaker, “is not a single process but a multiplicity of distinct though interrelated processes arising from different historical sources, proceeding at different rates” (p. 9). Weber writes about rationalization in relation to capital, markets and factory production, for example; but he also does so with respect to Protestant asceticism. In different analytical contexts, the term takes on distinctive nuances and meanings (Allen, 2004).

Despite this, the language of managerialism remains, to a degree, an obligatory currency through which to enact and characterize aid work.

“A CRITICAL PERSPECTIVE FROM A FIELDWORKER”

In a 2008, Yugoslavia-born Slovenian psychiatrist Anica Kos published an article titled, *The Pitfalls of Psychosocial Evaluation: A Critical Perspective from a Fieldworker*. The journal in which the article was published, *Intervention*, was founded in 2003 by the War Trauma Foundation, a psychosocial NGO based in the Netherlands, which dedicates itself mainly to questions of efficacy in humanitarian mental health. Its editors have periodically invited frontline practitioners to write opinion pieces about life in the trenches, and Kos, who had spent decades working with children affected by violence in war-torn Kosovo and Bosnia, had a lot to say about the ways in which psychosocial evaluations were being conducted in in Bosnia.

Kos has years of “experience in both ‘*being evaluated*’ and in ‘*being an evaluator*’ of community-based psychosocial programs” (p. 58). In theory, she writes, evaluations of efficacy are important tools for learning and improvement: they can “foster a culture of critical reflection” (p. 57), as well as counteract the tendencies of aid actors to be swept up uncritically in the touching narratives of a few beneficiaries who are not representative of the whole population. Yet despite their promise, Kos argues, evaluations have increasingly become a mechanistic search for variables that can be measured quickly, at the expense of important but difficult-to-quantify impacts.

Kos provides compelling examples from her aid experience. Training workshops she helped run were often evaluated in terms of recipients’ attendance, a surprisingly widespread measure that said little about an intervention’s quality or content. Other evaluations, meanwhile, asked recipients to fill out numerical questionnaires asking how much knowledge they had

gained from a given workshop, from 1 to 5. As Kos points out, these are not the most honest of situations: participants tend to give high marks regardless of how useful a workshop is, whether due to peer pressure or an obligation to show gratitude to the foreign NGOs that have wined and dined them. In other instances, Kos saw evaluators requesting a pre-post testing of children's academic abilities, assuming that an effective intervention would improve not only mood, but also scholastic performance. But such tests, Kos argues, do not capture more nebulous concepts like joy and sorrow. "Many evaluation methodologies, she writes, emphasize "symptoms of traumatization, neglecting less 'scientific' categories of benefits such as joy, increase of activity, or empowerment" (p. 59).

Kos (2008) recalls a Danish psychosocial aid program that distributed sandwiches to poor Kosovar children three times a week. She did not know if the program was formally evaluated for its efficacy; but she did know that the program was praised by children, parents, and teachers more than any other local program in recent memory. For Kos, this meant that a "project can be can be very useful without obvious results in fulfilment of its goal, for example reducing symptoms of trauma. It can simply demonstrate to children that somebody is caring, that there is goodness and humanity in the world" (p. 60).

Unfortunately, many evaluators do not seem to realize this, and insist on more formal measures. Despite increasingly "collaborative" rhetoric, consultants still have considerable power to decide whether or not a program retains its funding. Since internal evaluation is often biased in favor of program continuation, donors commonly prefer external consultants, yet these often came from afar for short periods, possessing little knowledge of the program or the local population. "Fieldworkers sometimes wonder why so much money is spent on consultants from fashionable consultancy firms," Kos writes, "who, for a fee of several hundreds of dollars per

day, travel for a week or so to a post disaster area, rearrange all of the project activities and end up writing a report that will gather dust in the archives” (2008, p. 63).

In addition to missing important impacts that cannot be measured, some forms of evaluation are also culturally tone-deaf. An evaluation consultant once matter-of-factly requested that teachers in Kosovo document children’s behavioral issues in biweekly reports, to illustrate improvement over time. For locals, however, Kos (2008) notes, such information was considered exceedingly sensitive and private, and asking for it would have not only offended their parents, but also taxed the already overworked teachers. The potential for wider abuses is high, Kos argues; conflict zones like Kosovo are a “promised land” for data collection, not only for evaluators but also for researchers who seek to travel alongside them (p. 62).

Like Kos (2008), psychotherapist Guus van der Veer (2008) notes that while some donors are satisfied as long as practitioners “interview a few beneficiaries and write down their stories,” others increasingly want “quantitative results that can be analyzed through statistical methods” (p. 22). He finds it ironic that in his 35 years of working in mental health institutions in the Netherlands, he was never once evaluated in this manner; yet aid donors will insist on “hard evidence” of efficacy for a project in which they have invested only 50,000 Euros (p. 22).

Kos’ (2008) critique in the *Intervention* journal is followed by a brief response article by Wietse Tol and Mark Jordans (2008), two aid scholars and industry insiders who participated in the 2007 IASC guidelines’ writing committee. The reality Kos describes is unfortunate, Tol and Jordans write, but contrary to her supposition, they claim, it is not an indictment of the aid field itself: “The ‘horror stories’ Kos describes, though indeed pointing to unprofessional and unethical practices and necessary changes that should occur in these practices, should not

obstruct our resolve to move towards a field in which practice is based on as sound evidence [sic] as possible” (p. 66).

Tol and Jordans (2008) concur with Kos that evaluations are often not collaborative, nor are they conducted with an effort to carefully understand local conditions. Sometimes, too, they concede, the data collected are used for purposes that do not benefit locals directly or indirectly, and without seeking locals’ consent. They likewise concur that donors tend to favor quick, easy to measure solutions over longer-lasting ones. In this respect, they write, widespread practice in the field still falls short of the 2007 guidelines’ emphasis on “participatory, collaborative, inclusive, action-focused, [and] culturally appropriate” evaluation (p. 66).

But despite these unfortunate realities, they argue, aid actors still have the ability to conduct evaluations of interventions that are both “methodologically rigorous” and “ethically sound” (p. 67). The best way to do this, they suggest, is to blend quantitative with qualitative methods to get at those aspects of interventions that cannot be quantitatively measured, seek proper “consent” from locals, and make sure that evaluations are subsequently put to “good use” (p. 66). Above all, they conclude, it is vital not to stop evaluation altogether, but rather, to aim for greater scientific rigor that in the long run will construct an evidence base for effective psychosocial interventions, for the benefit of aid recipients everywhere (p. 68).

For Tol and Jordans, the challenges of evaluation boil down primarily to the methods and choices of consultants and evaluators. Even though they concur with most of Kos’ particular reservations, their emphasis on what individual actors should and should not do implies that they see many of these problems as faults in rigor, fixable using the proper methods. Kos, in contrast, critiques a system: namely, she finds fault with the political economy of aid and evaluation, and more specifically, with the short-sightedness of a growing global movement to align

humanitarian assistance with principles of calculability. This movement, Kos argues, constrains the kinds of interventions and evaluations that aid actors can conduct, and neglects or underfunds important interventions that locals find meaningful. Unlike Tol and Jordans, Kos claims individual consultants have little power to resist this, to insist upon more “culturally appropriate” interventions, or to determine the course an evaluation will take.

Tol and Jordans also differ from Kos in their view on aid measurability. Sidestepping Kos’ (2008) argument that some important benefits of aid are impossible to measure, they side firmly with the benefits of quantification by advocating a blend of quantitative with qualitative methods of evaluation wherein the latter still serve as handmaidens to the former. For example, while it is “helpful,” they concede, to conduct semi-structured qualitative interviews and focus groups with affected families, they clarify that such studies primarily aid “in making our quantitative efficacy research more contextually valid” (p. 67).

I raise Kos’ debate with Tol and Jordans regarding the ethics of evaluation in order to introduce some of the important stakes of aid rationalization that are addressed in this chapter. It is no accident, I suggest, that Kos’ view is primarily from the front lines, while Tol and Jordans comes from the policy and research fields. Kos has a front row view of subtle aid impacts that those from afar cannot measure or see (for example, the joys that children may experience simply from knowing others care about them). She sees the neglect of such impacts as a serious problem that can harm aid recipients. Meanwhile, Tol and Jordans, who take a wider view, care about ensuring better accountability in the field at large. Mindful of the parachuting controversies that have dogged the field, they believe that subjecting aid workers and evaluators to common standards based on rigorous testing will help ensure that interventions and

evaluations do not reflect the arbitrary will of particular practitioners, but are rather subjected to quality control by a community invested in the well-being of humanitarian aid recipients.

There is no doubt that Kos, Tol and Jordans all share a desire to improve the lives of aid recipients. Yet by framing improvement in terms of quantification, rigor and the competence of individual aid actors, I suggest, Tol and Jordans are neglecting significant economic and political processes that impinge upon aid work. Like the 2007 guidelines' omission of aid funding cycles in the previous chapter, I suggest, Tol and Jordans' prescriptions depoliticize aid by presenting it as a field of identically positioned, rational actors seeking to abide by the dictates of science. In the following section, I explore the epistemological underpinnings of Tol and Jordans' argument by examining logical frameworks, a means of planning and auditing aid interventions that strives for this kind of rationality.

GOVERNING AID THROUGH LOGICAL FRAMEWORKS

The logical framework (logframe) is a “project matrix:” an aid monitoring and planning tool wherein an intervention is broken down into sequential components: inputs (resources), activities, short-term outcomes, and long-term impacts, typically specified in quantitative terms (Gasper, 2000, p. 18). Often traced back to U.S. military planning and corporate governance in the mid and late 20th century (Dar & Cooke, 2008; Gasper, 2000; Kerr, 2005), logframes became an inseparable part of the rising humanitarian managerialism of the 1980s and 1990s. Concerns about inefficient, wasteful, or incompetent aid work prompted donor governments to promise their taxpayers better evidence of poverty reduction and aid efficacy in the developing world; logframes became an important mechanism in the actualization of this grand project (Kerr, 2005).

Aid donors now almost universally require logframe-style reporting as a condition of funding (Gasper, 2000; Kerr, 2005; DFID, 2011).⁴¹ Logframes accompany aid projects from the beginning to the end of their lifespans: funding proposals describe future interventions in terms of inputs, outputs, impacts, and beneficiaries; mid-project reports revisit and tweak these plans and indicate how faithfully they have been followed; and final reports reflect back on desired and achieved impacts in similar language. While aid organizations increasingly experiment with different formats and varieties of reporting frameworks (Gasper, 2000; Jones, 2006), they all generally assume a causal and linear relationship leading from inputs to activities to outputs to impacts. Furthermore, it is generally assumed that the referents to which inputs, activities, outputs, and outcomes gesture can be clearly delineated, specified, and measured.

Like the 2007 IASC guidelines, logframes possess both practical and symbolic dimensions. As James Scott (1998) has illustrated with respect to the census in France, the purpose of the logframes is not merely practical (to aid in monitoring projects from afar) but also cultural (to make aid work increasingly rational and systematic). At their base, however, is the brute fact of mistrust: logframes constitute an important example of “audit-based accountability” (Gasper, 2000, p. 17) whose central premise is the “mistrust and opacity [that] pervade humanitarian financing and donor behavior” (Smillie & Minear, 2003, p. 1; see also Porter, 1995; Rottenburg, 2009). Donors, despite their power to grant and deny funding, realize they exist at an important knowledge disadvantage relative to their contracted agents. Logframes are one of the most widely used mechanisms to compensate for it.

⁴¹ A 2011 DFID (UK Department of International Development) bulletin reads, “From January 1, 2011, logframes are mandatory for all newly-approved DFID regardless of value, removing the previous 1m mandatory logframe threshold” (DFID, 2011, p. 6).

Logframe instruction manuals and memos present rational management as the solution to the lackluster impacts of many aid projects. In one DFID instruction manual, logframe use is equated with “sensible planning” and “clear, logical thought,” which are seen as necessary in order to tackle the “ever-changing challenges of poverty and need” (DFID, 2011, p. 7). Actors who use logframes, in turn, are said to make “evidence-based decisions, where possible supported by sound statistics and independently verifiable data” (p. 9). I have found multiple references to clarity, sensible thought, transparency, systematicity, quantification, statistics, and logic in over a dozen other logframe manuals by different aid organizations. In all of them, the precise relationship among logframes, evidence, and statistics remains unelaborated. Like psychosocial aid workers’ claims to doing “evidence-based” work (chapter 3), associations of logframes with rationality and science are often expressed in a broad idiom.

Logframes afford their users particular ways of seeing (Scott, 1998). Following the notion of co-production (Jasanoff, 2004), logframes both assume that important dimensions of frontline aid work can be compressed into discrete, observable units that can each be assessed in terms of their efficiency and results; and they also *make* them so, by requiring aid actors to design interventions in accordance with this model. In other words, logframes render their subjects auditable. To explain this point, I would like to draw upon anthropologist Elizabeth Dunn’s (2004) work on a baby food factory in post-communist Poland named Alima and its workers’ adjustment to a capitalist takeover by the American conglomerate Gerber. Even though Dunn does not discuss logframes or aid, her description of the capitalist takeover, I argue, captures important dimensions of how logframes work in the aid sphere, which I will shortly address. For Dunn, reducing labor into measurable units is a way of making workers and their

labor auditable – an example of corporate governance *par excellence*, a realm known for its “audit-based, quality-control systems” (p. 19).

Dunn employs the concept of *auditability* to explain what happened to Polish workers with Gerber’s takeover of their Polish factory, Alima. In the pre-takeover Polish shortage economy, she writes, Alima workers generally had to use whatever agricultural produce was currently available. This meant that they had to change their production plans frequently to suit the demands of an unpredictable economy; state-owned Alima calibrated itself to compensate for such contingencies by purchasing whatever local farmers were selling despite variations in quality.

When American Gerber managers arrived at newly acquired Alima, they discovered to their dismay that quality and stock were not standardized to the degree that had expected. In addition, the company’s many financial liabilities had been left off the books. Unofficial deals and concessions that had been necessary for survival in a shortage economy had been omitted from the company’s socialist-era accounts. For instance, Alima had assumed responsibility for maintaining workers’ apartments, but the cost of doing so was not noted in the company’s books. Additionally, in order to ensure the company’s survival in a shortage economy, socialist-era Alima managers had regularly doctored company accounts to make it seem as though greater government subsidies were needed. Personal debts dominated production lines, diverting a small stream of resources and profits in secret, heeding innumerable unwritten agreements. For Gerber’s newly appointed American managers, then, the company seemed “fundamentally inauditable” (Dunn, 2004, p. 41).

American managers then commenced a lengthy effort to transform the company they had purchased, and its workers, into “auditable” subjects who would produce a product of

standardized quality, in a reliable, rule-bound, and self-governing manner. In other words, Dunn argues, they sought to transform Polish laborers into what Nikolas Rose and Peter Miller (1992) have called the self-regulating ideal workers of neoliberal economies – workers who could be trusted to govern themselves in line with the boss’ expectations. But Polish workers did not readily comply with their new American bosses’ expectations of transparency and self-regulation. They alternately resisted and schemed against their American employers, maintaining old patrimonial relations until threatened with dismissal.

The logframe model in the aid sphere, I suggest, is predicated upon a similar philosophy of accountability, whose aims have been to remake aid work into a systematic, rational series of actions with clearly auditable moving parts. As in Alima’s socialist-era days, however, aid work, like any job juggling numerous and unpredictable moving parts, is difficult to make predictable or auditable. As I argue in the remainder of the chapter, the efforts and failures of aid governance resemble Dunn’s (2004) narrative in important ways; I will return to Alima specifically at the end of this chapter.

READING LOGFRAME INDICATORS

Logframes’ translation of frontline practice into inputs, activities, outputs, and outcomes implies that once a goal is specified, it should be possible to determine whether that goal has been reached, or in other words, to find “indicators” of the desired outcomes (for example, lower childbearing rates might be seen as an indicator of the “rising status of women.”) A DFID (2011) logframe manual makes the measurement process sound simple: “if you can measure it, you can manage it.”

But scholars and aid workers have increasingly questioned this assumption (Kerr, 2005; Merry, 2011). In particular, they have pointed to the ambiguity that surrounds what aid actors

should measure and what the measurements themselves would mean. I once heard a lecture by an American organizational researcher about how to “wisely” adapt efficacy indicators from the corporate to the humanitarian sphere. After his talk, a woman spoke up from the audience. Identifying herself as a former employee of USAID,⁴² she questioned whether efficacy measures were as clear as he had seemed to assume. As a project evaluator, she said, she had often struggled to decide which logframe-worthy indicators the ambiguous phenomena in front of her corresponded to.

As she explained to the group, USAID had once poured significant funds into local civil society organizations in Venezuela as part of a broader democratic reform initiative. During this time, she recalled, there were extensive workers’ strikes throughout the country. Yet she did not know how to account for these strikes in her reports: did they indicate a positive effect of USAID funding, since they implied the existence of political space in Venezuela for protest, striking, and free assembly? Or were they rather a negative indicator, reflecting the entrenched, state-approved exploitation of the laboring class? She and her colleagues had the freedom to decide for themselves how to frame these strikes, and they realized that multiple interpretations could be defended with equal persuasiveness. Yet once couched in the bureaucratise of USAID memos, their decision would lose much of its underlying ambiguity, unbeknownst to those on the receiving end.

Citing Porter (1995), Sally Engle Merry (2011) notes that numerical indicators have enormous power to smoothe relations among distant aid actors, not only by offering a common medium for comparison of disparate entities, but also by creating impressions of objectivity. “The power of indicators,” Merry argues, is seen as residing in “their capacity to convert

⁴² United States Agency for International Development.

complicated contextually variable phenomena into unambiguous, clear, and impersonal measures. They represent a technology of producing readily accessible and standardized forms of knowledge” (p. 84). However, while the indicators that are chosen to represent particular aid goals possess enormous power to determine where funding is subsequently sent, deciding which indicators to use, and how, remains a politically fraught process.

For example, as Merry (2011) notes, the timing of marriage is of interest to human rights actors because it correlates with maternal health, family formations, and gender-based violence. However, human rights actors have struggled to decide how early marriage might be operationalized, given that “not all societies have recognizable wedding ceremonies, nor do they necessarily lead to first sex or cohabitation” (p. 86). Which indicators should human rights actors use to determine marriage: age of betrothal, age of cohabitation, age of first sex, or the wedding ceremony itself? Not only does each indicator vary in prevalence throughout the developing world, but each also carries a different meaning. Betrothal might indicate forced marriage; cohabitation is often associated with an end of schooling for girls; and age of first sex might indicate medical complications arising from young childbearing. Choosing one over another would invariably leave out important information. But this, Merry (2011) argues, does not prevent human rights actors from presenting such choices as objective and neutral, coupled with ample numbers and statistics to round out the impression of rationality.

Another difficulty in choosing indicators is found in Stein’s (2008) discussion of food dependency. Food aid organizations frequently measure food aid dependency among their recipients as a proxy for need at large (i.e., a community that is food aid-dependent is not thriving on its own). But dependency, Stein notes, “has no unambiguous empirical referents” (p. 136). A family might be counted as “dependent” on food aid as a function of the physical

quantity of food they possess. But dependency might also be seen as a function not simply of the quantity of food, but rather of its predictability in the household. Like Merry's (2011) example of early marriage, Stein's (2008) shows that operationalizing "dependency" requires considerable contextual knowledge: indeed, dependency should be measured differently depending on the circumstances of the aid recipients at hand. But as far as a logframe user is concerned, different measures for different contexts would defeat the purpose of quantitative comparisons along standardized dimensions. Thus, the use of logframes requires ignoring contextual differences in how its variables might be operationalized.

CRITIQUING LOGFRAMES

The use of logframes to order, plan and govern aid work has been subject to various criticisms. These, I suggest, can be roughly divided into knowability critiques (i.e., to what extent the logframe can truly "see" frontline aid practices) and political critiques (i.e., whose interests the logframe model serves). One knowability critique alleges that logframes impose a false order upon aid work: in practice, activities, inputs, outputs, and outcomes do not line up neatly or discretely, and numerous additional variables come into play during an intervention (Jones, 2006). Referring back to chapters 1 and 2, Lipsky's (1980) notion of frontline discretion by street-level bureaucrats would be an important example of this, as would AHE aid workers' *combinot*. The logframe's mechanistic theory of causality, Oliver Bakewell and Anne Garbutt (2005) argue, fails because aid workers rarely operate in self-contained casual systems.

Some aid insiders readily acknowledge this critique, calling it the "attribution problem," or the difficulty of attributing any apparent effects seen on the ground to a particular intervention, since in aid settings – as in many others – so many parts are moving at once

(Hofmann et al., 2004).⁴³ While industry outsiders have used this critique to question logframes' ability to capture aid work, insiders have tended to take the venom out of this critique by incorporating them into a narrative of gradual improvement.

If the attribution problem concerns misrepresentation of frontline practices, other critiques accuse logframes of actively altering the course of aid work by forcing aid workers to stick to an original plan even when it is no longer workable. Gasper (2000) calls logframes “lock-frames,” arguing that “distance and low trust contribute to the lock-frame syndrome, because of fear of loss of accountability if receivers are allowed to modify what was earlier agreed” (p. 22). While donors and NGOs will often publicly acknowledge the need to learn from mistakes and to flexibly adapt to new circumstances, Gasper argues, logframes tend to assume the status of hallowed social artifacts that, once written, few donors and supervisors are willing to change; even project managers and frontline aid workers get locked into such plans. This “ethical critique” sees logframes as being implemented in an authoritarian way, subservient to the dictates of managers and donors while neglecting the perspectives of frontline workers and aid recipients.

Logframes tend to simplify the human landscape.⁴⁴ By asking aid workers to specify their “direct beneficiaries,” “indirect beneficiaries,” short-term outputs, and long-term outcomes, for example, logframes tend to imply that a project’s different stakeholders agree on who these

⁴³ Kos (2008) also points out that positive effects, such as a decline in regional violence, are often attributed to a program that might have little to do with them. In other cases, the opposite occurs: a program is blamed for events beyond its control.

⁴⁴ Some efforts, admittedly, have been made to expand and diversify logframes by allowing them to account for both the complexity and uncertainty of aid outcomes. For example, in 2000, Canada’s International Development Research Centre (IDRC) proposed a tool known as Outcome Mapping (OM) (Jones, 2006). Designed to be a more flexible counterpart to the logframe, OM purports to accommodate the non-linearity and unpredictability characteristic of aid work. While it has met with enthusiasm among a number of NGOs, critics have characterized it as too lengthy and arduous to put into practice, and more traditional logframes remain the industry standard.

beneficiaries are, and on what the project's goals are (Gasper, 2000). Any disagreements or ambivalence are typically omitted. In a sense, this is intentional: as Bowker and Star (1999) have observed with respect to statistics, technologies of simplification are a must when attempting to govern human populations. Ted Porter (1995), writing about the typical omission of detail from scientific papers, frames this point well:

The literary technologies of the modern scientific paper are inadequate to convey the tacit richness of experimental technique, or, for that matter, the arcane craft of formulating theories. For most purposes, especially when knowledge crosses the boundaries of community, *such intimate knowledge is not particularly desired*. The value of *superficiality* has been argued by Peter Galison, who observes that the interactions among instrumentalists, experimentalists, and theorists in physics are a bit like a trading zone, involving, say, European merchants and South American Indian craftsmen or farmers. Religious, cosmological and ideological meanings are lost; the traders only need to agree on a price, a number or ratio (p. 86, emphasis added).

As Porter (1995) puts it, complexity, however valuable it is in some contexts, is not always valuable to everyone; it can get in the way of grasping things quickly and getting things done. Among logframe proponents, this is a prevalent way of thinking: epistemic short-cuts have to be made in order to enable aid work to proceed at a reasonable pace. As James Scott (1998) has illustrated with respect to the creation of surnames and street names, procedures of simplification are central to the creation of legibility in modern nation states.

Yet epistemic shortcuts of this nature can result in over-simplification. For example, one 2011 DFID logframe instruction manual acknowledges that there is not one language for discussing aid; different aid actors will frame aid outcomes and challenges in competing ways. As the manual notes, "Until the point is reached where all those engaged in humanitarian and development activities use a single language, DFID will have to work with the fact that multiple partners mean differences in terminology and approaches." (p. 20). So far, the epistemic plurality of the aid sphere seems to be openly acknowledged, if grudgingly so. The manual then

changes course, however, to state that while DFID recognizes the importance of reconciling competing opinions among different aid actors, such reconciliation processes should not result in excessive relativism or a lackadaisical attitude to data collection: “it is important that in pursuing a harmonization agenda, we do not relax our requirements for robust monitoring and evaluation tools. Differences in language and approach should not be an excuse for gaps in information” (p. 20).

The word “information” is given an interesting meaning here. The manual acknowledges that different aid actors use different languages for describing aid; yet by insisting that such differences should not be dwelled upon at the expense of “robust” evaluation and collection of “information,” the manual neglects the fact that information, too, is one of those contested notions. For aid workers who struggle to fill out logframes, it is the very definition of information that is implicit in these tools which should be problematized.

The DFID manual does not acknowledge that what might be deemed worthy of being called information is often a contested matter in its own right. On the contrary, information in this document is essentialized through a broad insistence that aid workers carry on gathering information and cease to make excuses for gaps in it. According to an Oxfam report critical of logframe rationality, such practices count as a classic example of “skewed accountability,” which prioritizes the needs of donors beneath a veneer of objectivity and pure information-seeking (Ahmad, 2011, p. 12). In other words, this example illustrates that logframe proponents can perpetuate top-down aid practices by granting only those at the top the power to decide what counts as valid information about humanitarian aid-giving.

In their presumption that aid actors agree on what counts as “information” and how best to gather it, logframes can be helpfully understood, I suggest, as an example of James Ferguson’s

(1990) anti-politics machine. A 1975 World Bank report, Ferguson writes, described Lesotho as a “traditional subsistence peasant society” that was “virtually untouched by modern economic development” (1994, p. 176), despite the fact that most of its population had long been employed in South Africa’s mines and industry. In reality, Lesotho’s ills were intimately tied to its economic dependency on and political subjugation to South Africa, but UN and aid organizations rarely mentioned this fact, perhaps because they had no interest in getting involved in political disputes between the two countries.

Development actors took pains to present Lesotho as an untouched territory in need of external technology and expertise, while ignoring issues of structural unemployment, resource extraction, and labor exploitation in South Africa. In so doing, Ferguson argues, they effectively took the “politics out of development,” rendering development itself an “anti-politics machine” (p. 178). As Tania Li (2007) has similarly observed, numerous aid and development actors view development as a technical matter of transferring knowledge and technology from the developed to the developing world (see also Escobar, 2005). We might see logframes, I suggest, as operating in a similar way. Highlighting the clarity and order to which logframe-based actions adhere, I suggest, allows logframe proponents to strengthen the image of aid as technical and apolitical. From another perspective, logframes depoliticize aid, reducing politically charged notions of humanitarian accountability and effectiveness to one-dimensional, supposedly value-neutral concepts like “objectively verifiable indicators.” Indeed, critics like William Easterly (2002) suggest that this has, to a large degree, already happened throughout the aid sphere.

As anthropologist Kregg Hetherington (2011) has shown, anti-political claims about information-gathering in development contexts are also articulated in more subtle ways. Recalling the 2011 DFID manual that requested that aid workers refrain from making excuses for

not gathering information, the de-politicization of the term is also of interest to Hetherington, who wishes to understand how it can happen even when objects of knowledge are not thoroughly scrubbed clean, as logframes are, from any obvious semblance of politics. Hetherington shows with respect to recent cadastral reforms in Paraguay that the notion of information can serve fundamentally anti-political moves even when accompanied by claims to empower the poor.

In Paraguay, rural land ownership has until recently been largely informal and unregistered. In partnership with international creditors, the Paraguayan government commenced a massive cadastral reform to map and register rural areas, ostensibly in order to expand the tax base and develop the rural economy. The government has insisted that the problem for rural smallholders so far has been the lack of reliable “information” about who owned what land. Cadastral reform, they have promised, would replace the unreliable land registries of the past, bringing with it transparency, modernization, and more rights for the average farmer, thanks to the “information” about land parcels that would now be accessible to everyone, and which “everyone” could use in order to participate as rational actors in the rural economy.

Contrary to government promises, Hetherington (2011) notes, many farmers still lack the economic and political capital to “participate” as buyers and sellers in the rural economy. Those unable to acquire formal deeds to the land their families had been living on for centuries, moreover, will likely lose it under the newly mapped system. Nevertheless, development experts, he argues, persist in using terms like “information” and “knowledge” to connote democratic rights and economic growth. In Paraguay, Hetherington concludes, uses of such terms have been “productively vague,” enabling government and development actors to seem like champions of the weak by spreading information to the masses, whilst hiding the fact that farmers are

positioned differently with respect to information than are government actors: information is not genuinely for everyone (2011, p. 127.)

Like Hetherington's (2011) development actors, logframe proponents do more than present evaluations as neutral, objective processes. Because they are very familiar with tropes of participation and recipient-led aid, they know it is important to pay lip service not only to rationality, but also to the equally omnipresent participation orthodoxy of the humanitarian sphere (Leal, 2007; White, 2010).

MAKING AID AUDITABLE

How do logframes affect frontline aid practices? Numerous studies have suggested that NGOs tend to find little utility in logframes and fill them primarily out of necessity, tweaking them in an ad-hoc manner to fit interventions already underway (Bakewell and Garbutt, 2005; Ebrahim, 2003; Gasper, 2000). In a critique of logframes funded by the Swedish International Development Agency, for example, Bakewell and Garbutt (2005) suggest that NGOs "will prepare logical frameworks... when it is necessary to satisfy donors. To some extent, the LFA [logical framework approach] in this sense can become superficial packaging which covers up the real way of doing business" (p. 8). Such studies cast doubt on whether logframes can truly help NGOs with planning their work, as logframe proponents claim, or are mainly used to fulfill donor requirements. Yet the importance of logframes exceeds their workability by frontline aid actors; logframes also have the potential to change the ways in which aid is conceived and enacted.

After learning about logframes for the first time, I was curious to see how filling them out might be different in a mental health NGO relative to, for example, a water- and sanitation-focused NGO. In other words, would "objectively verifiable indicators" be harder to specify for

psychosocial projects than for water pump and drainage projects? I quickly discovered, however, that psychosocial interventions were so diverse that this question could not be answered in any general way. Some psychosocial projects, for example, were vocational training or cash-for-work programs; funds disbursed and jobs gained were relatively easy to quantify or find indicators for. Other projects, however, were more broadly conceived. While some of my informants suggested that psychosocial projects could be more easily tweaked to fit different logframe requirements and grant descriptions than more narrowly conceived forms of aid, others countered that the potential flexibility of the psychosocial category put donors on guard for this very reason.

To exemplify the former point, an American aid worker I shall call Milena described a women's empowerment group that she and some colleagues had run in Pakistan for a year. When their "psychosocial" project funding ran out, she recalled, they tweaked their project description to fit a new "income generation" budget line. This worked well, since their women, she said, were weaving baskets for sale in the local market – an activity that was easy to justify in terms of both "income generation" and mental health. Increasingly, Milena added, "gender-based violence is the fashion, so [now] we got funding for it... here, we wanted to work with men as well as women. When a donor told us 'we don't work with men,' we said, 'but if you don't let us work with perpetrators, how will we fix the problem?'"

In another example of tweaking, Larena described a psychosocial project in a Chechen refugee camp in Poland, which was run by the French branch of MSF. Larena had been sent there to provide psychosocial support to families in the camp who had suffered lengthy bouts of violence, primarily from Russian soldiers. Along with some colleagues, Larena attempted to set up a daycare center for children to give their overwhelmed parents some respite. But her MSF

supervisors refused to oversee such a project, claiming that daycares were the long-term responsibility of the Polish camp administrators, and lay outside MSF's mandate. Realizing that camp administrators were unlikely to cooperate with such a plan, Larena changed her request, asking MSF simply to purchase toys and coloring instruments for "psychosocial activities." Her supervisors agreed (quietly intuiting her true intention, she guessed), and these toys were gratefully used in the new "daycare" that was quietly constructed.

Milena presented logframes largely as a manageable nuisance. She indicated that they were relatively easy to write post-hoc, especially in the case of mental health, in ways that fit what aid workers had *already* done. However, she and other informants noted that on a global scale, relatively few NGOs possessed the knowledge of how to navigate logframes successfully in order to obtain funding. Writing grant proposals and outcome reports *well* meant knowing how to translate abstract notions of rationality and sustainability into specific activities that technocrats would appreciate, and to intuit, based on a donor's profile, what had to be truly "verifiable" and what could be glossed over or described in minimal detail. Even the difference between direct beneficiary and indirect beneficiary, Milena explained, was not an intuitive matter to ascertain. In Milena's experience, NGOs that navigated this inscriptive challenge successfully and received funding tended to be the larger international NGOs. Smaller and local NGOs, including ones doing important grassroots work, often saw their funding efforts fail due to their inferior fluency in logframe idioms.

The funding architecture of aid work, my informants noted, also made it difficult to circumvent logframe restrictions. The breadth of the psychosocial category did permit some leeway in defining and describing interventions, but short-term grants still ended, and external consultants did still fly in from afar to exact judgments that closed projects down or took them in

directions which frontliners often found curious or unjust. In 1999, Milena recalled, the United Nations World Food Programme sent in consultants to estimate the nutritional needs of families in rural Pakistan, where Milena had been living for two years. The consultants determined that a 2-liter tin of oil was what a family would use in a month. But Milena had seen many families go through a 2-liter tin of oil in a matter of days. Her efforts to tell the consultants as much, however, went unheard.

Aid evaluators and external consultants, as Anica Kos (2008) noted, often deploy quantitative measurements of efficacy and require aid workers to reframe their work accordingly. Yet as R.L. Stirrat (2000), an aid scholar and former consultant himself, has argued, the role of the outsiders is not purely that of actual consulting and evaluating: “Short-term development consultants are employed in the development industry ostensibly because of the pragmatic impacts their work on development is thought to have. Yet in practice,” he argues, “their work is judged more by aesthetic than pragmatic criteria” (p. 31). For Stirrat, consultants’ primary importance to donors is that they help hide the irrationality that characterizes aid work. Donors rarely take the work of consultants as seriously as they claim, he argues, and frequently hire the latter to tell them what they want to hear.

Consultants’ evaluations of the aid sites they’ve just visited, Stirrat notes by example, are subject primarily not to substantive review, but rather primarily to “aesthetic judgments.” A “good” report, for example, is one that is clearly written and makes repeated appeals to objectivity and rationality, regardless of its content (p. 41-2).⁴⁵ This stands in obvious contradiction, Stirrat writes, to the presumption of rationality upon which development consultancy rests, according to which “consultants can somehow penetrate to the ‘truth,’ the

⁴⁵ See Riles’ (2001) discussion of the aesthetic dimension of documents.

essence of what is going on in the world they are seeking to change, and that they can do this with the analytical tools which their ‘modernity’ puts at their disposal” (p. 37). Stirrat’s work, then, implies that consultants are *both* donor puppets who are hired to say what donors want to hear *and* harbingers of rationality and transparency, contracted to assess efficacy and promote the cause of rational reform throughout the humanitarian sphere. While this duality seems contradictory, it may illustrate precisely why frontline practice remains caught between indeterminacy and quantitative governance. While many aid actors implicitly concur with Stirrat’s critique, the aid sphere as a whole can hardly abandon its governance efforts; too much would be risked by powerful aid actors who might consider making public acknowledgements that aid rationalization is a more aesthetic than practical movement.

This is not the first time that aesthetic arguments have arisen in this dissertation to characterize the significance of humanitarian aid. In chapter 2, I similarly described how the appearance of chaos at AHE’s clinic tended paradoxically to legitimize the organization’s failures by corresponding to aid actors’ emergency imaginaries (Calhoun, 2010). This happened because particular visual aesthetics (like a crowded clinic and broken computers) as well as certain temporalities of aid (frenetic motion on the brink of collapse) cohered with some aid workers’ notions of what “real” aid work looked like. Yet in the consultancy case, an opposite aesthetic is being deployed: as Stirrat argues, consultants rely on quantitative technologies of inscription that reinforce the image of rationality. What this tends to hide is the work of negotiation among human actors that feeds into the creation of such numbers and inscriptions.

Richard Harper (2000), in his ethnographic study of IMF auditing, provides an important example of the hidden negotiations of development consultancy. Harper’s IMF auditors were tasked to collect data about one aid-receiving country’s economy, which the country must

provide as a condition of IMF lending. These numbers, the auditors discovered upon their arrival, were partially missing, and others seemed of perplexing origin. But they collected them nonetheless, and then commenced the delicate work of bestowing legitimacy upon these numbers by having the “right” sort of authorities sign off on them, thereby affirming their status as true representations of the country’s economy.

This example provides a poignant illustration of how numbers, though they may serve as technologies of trust (Porter, 1995), are themselves reliant upon trust and social negotiation. Harper’s auditors come across in his chapter as reluctant believers in aid rationality at best, but they have to keep up appearances as part of their jobs. Harper, it is important to add, does not dismiss these numbers as nonsensical or meaningless. On the contrary: while he seems to have expected his subjects to show surprise at their hosts’ shoddy data gathering, they do not seem surprised; indeed, they seem to take it for granted that some kind of tweaking and affirming would be necessary to make these numbers official. Their behavior suggests that they do not think they are acting as willing parties to a fraud or that the numbers themselves don’t count.

As Michael Power has noted, “audit documentation is only partly descriptive” (1997, p. 37). In the aid sphere, too, much of what goes on in the trenches is omitted from logframes and other audit documents, whether because frontline aid actors desire to omit them, or because it would be too difficult or costly to inscribe such information in the formats that prevalent audit technologies require. In the following section, I provide examples of frontline practice that tend to remain off the books.

WHAT LOGFRAMES MAY LEAVE OUT

In the West Bank, international NGOs have operated psychosocial projects since the beginning of the second Intifada in October of 2000 – if not earlier (Fassin & Rechtman, 2009).

Many of these projects have been connected to the Israeli military occupation, but most NGOs have been careful not to frame such interventions as an explicit attack of Israel, emphasizing instead their attention to the occupation's social and health ramifications (Wildeman, 2012). Medicines sans Frontiers (MSF), for example, has overseen dozens of foreign psychologists, typically young European and American practitioners, arriving in Palestine for a few months at a time. For the most part, they have conducted individual therapy sessions with local civilians through translators. Larena, the psychologist who had gone to Yushu in a previous chapter, volunteered for years as a senior advisor to some of these young psychologists, a role she called "helping the helpers."

In order to qualify for mental healthcare at this NGO, Larena explained, Palestinian civilians needed to have experienced a demonstrable "trigger relating to the conflict." But this trigger proved more complex to isolate from other factors than practitioners initially presumed. As Larena put it,

Where does it begin to get messy? When you go into a family, where it's reported that [Israeli] soldiers entered the house and took the eldest son.⁴⁶ And this created trauma for the whole family. And in this sense, they're part of [the NGO's] target population. That's their mission statement. Now they start to work with the family, and after 2 weeks, the 16 year-old boy returns from jail. But by then, they'll have discovered domestic violence [in the family] in a horrific way. What do they do? Do they stay? Do they leave?

As Larena describes, her supervisees encountered domestic violence on a regular basis among the families they approached. Over time, they realized this was an older social problem that could only be marginally linked to the military occupation. "The truth is it's never clean," Larena explained. "You can enter a family because soldiers had come the night before and humiliated the father, and the kids are in a very traumatic state: they don't sleep at night, wet the

⁴⁶ Presumably referring to arrest or administrative detention.

bed, and are afraid to go to school.” The longer you spent with this family, she continued, the more you realized that domestic violence there was not new, and not necessarily present because the father had been humiliated by Israeli soldiers.

NGOs found themselves in a bind: they were present to attend to the social effects of the military occupation, Larena explained, yet many local problems were not easy to relate to the occupation. A popular solution among her colleagues was to privately speak about domestic violence as a direct or indirect result of the occupation, but such arguments were not always persuasive. “Some say that the domestic violence is because the dad is unemployed, since Israel won’t let him enter Israel to work. But then you discover, wait, that the domestic violence in that home, actually it has always been there,” she said.

Aid workers in this region, Larena explained, were in a double bind. Intervening in a zone occupied by a U.S.-backed and funded country was a delicate enough matter: as several European aid workers explained to me, they always needed to walk a fine line between broadly criticizing harm to civilians and criticizing Israel. Several NGOs had angered Israel enough that their aid workers had been stopped at the border or the local airport and deported. Yet acknowledging local problems that were *not* occupation-related carried other risks. Tackling domestic violence as cultural outsiders, for example, with neither the knowledge of existing local efforts on this front nor the human resources to engage local civil society actors, would likely be read by local actors as Eurocentric posturing and meddling, an impression that NGOs sought to avoid at all costs.⁴⁷ It was difficult, however, to avoid an impression of meddling when therapy sessions were being conducted by foreigners, and were meant to help civilians cope with the

⁴⁷ Conservative actors might object to what they see as interfering with local power structures. But progressive actors and organizations, too, have frequently questioned the motives and efficacy of Western solidarity with the Palestinian cause, which may unwittingly impose foreign goals upon local movements rather than letting them design their own march to liberation (Alsaafin, 2012).

status quo. Young practitioners feared they were serving the occupiers' interests by helping Palestinians get used to, and "normalize," the realities of occupation, and to "survive the occupation a bit better." It was a fear that many locals themselves shared.

As Larena recalled, practitioners felt ill-suited to address complex local problems, but at the same time, also felt negligent for not doing so:

Even if they'd come into a family and witness domestic violence, they'd somehow work on empowering the mother *around* the situation, and not deal [directly] with domestic violence. And that created a feeling of negligence. Also, many times you can't tell what's going on. You go and you see a general picture that's complex, [including] both post-traumatic responses to the occupation, and also *other* things, contexts where you don't know what's the cause and what's the effect.

Perhaps it was because they sought to broach matters of the heart, and not simply give out medical supplies, that practitioners' sense of strangeness in the society they were visiting, and the risk of trivializing their beneficiaries, became evident to them rather quickly. For example, a young French psychotherapist once consulted Larena about his work with an 18 year-old girl. She had failed her high school classes and become volatile and violent towards her relatives, and her condition had recently deteriorated to include delusions and psychotic episodes.

To the young psychotherapist's amazement, the family was tolerating the girl's behavior even when she hit them, and refused to send her to treatment. He met with the family several times and explained that given her condition, pharmacological or inpatient care was what the girl needed. They again refused. "And then it came out," said Larena, "that the family had a hard time standing up to the girl, since if it became publicly known that she had all these issues, her sisters wouldn't be able to get married."

To this young aid worker, the family's apparent preference for keeping things quiet for the sake of the sisters' marriage prospects seemed inexplicable. Larena, not native to the region and unsure of what local services existed that the family could use without risking ruinous stigma, advised the young psychotherapist to respect the family's decision and try to understand the broader structures driving it. Incredulous and pained, he responded that in France, he would never in good conscience have condoned submitting to oppressive, patriarchal traditions at the expense of a family's sanity and health.

This young man's frustration was not unique, Larena noted. Most of her advisees, present in Palestine for only a short time, struggled to understand local cultural and political phenomena without instinctively invoking their own sense of themselves as being "more modern." They were also at a loss to comprehend the co-dependency among locals and the humanitarian industry. Many locals were employed by foreign NGOs and depended on their presence to survive, yet expressed frequent criticism of the projects that these NGOs chose to carry out, which were often short-lived and refrained from critiquing Israel openly. Locals' feelings of stasis and resignation surprised Larena's supervisees, who gradually began to feel like pawns in an industry invested in maintaining a hobbled status quo. For example,

A female psychologist comes to work with the family. For six months she works with the wife. And after six months, she leaves. And there's no anti-violence center, there's no law in the West Bank against domestic violence. There are women's shelters, but it's considered such a big social stigma that most women don't go there. So the female psychologists ask themselves, "What have we done? What have we done by being here for 6 months?"

Many practitioners, Larena included, felt that their own reservations about their short-term assistance could not be voiced openly, whether for fear of offending their beneficiaries or embarrassing the NGOs that had sent them by admitting their sense of futility. For this reason,

aid workers' sense of perpetuating a harmful status quo through "safe" interventions rarely made it to logframes or other reports. Stories of civilians feeling better as a result of therapy, and becoming more socially and communally engaged, were instead what they wrote about.

Someone privy only to official reporting from the region would be largely oblivious to aid workers' concerns about indirectly assisting the ongoing military occupation by helping its victims cope with it emotionally, or about forsaking individual suffering and complex social problems by not addressing domestic violence. At the same time, precisely because the complexity of action in the front lines could not be captured in reports, this proved an advantage to some aid workers, who could quietly intervene in ways their supervisors occasionally disapproved of.

The ethnographic examples I have provided emphasize knowledge asymmetries between frontline practitioners and aid actors located far from the front lines. While such asymmetries arise often, they are not unitary or simple; the tidying up that is done through inscriptive technologies like logframes does not succeed in entirely removing the messy realities of aid work from the view of donors and managers.

A donor is not a single or monolithic actor. Typically, donors are teams that represent complex institutional bodies, be they governments, NGOs, foundations, or UN-affiliated institutions. Many donor employees have served in other aid capacities in the past, and have developed a sophisticated understanding of how frontline practice is smoothed over in reports. Various informal means or back channels exist, moreover, by which these employees can sometimes come by information left out of official reports. In the final section of this chapter, I describe how this might happen, in an effort to explore the widespread reflexivity about aid indeterminacy and failure that exists in numerous humanitarian institutional settings, as Jo de

Berry, the World Bank consultant, has noted. To set the stage, I begin with an ethnographic vignette describing one of AHE's medical missions to the West Bank.

GERMAN-FUNDED AID IN THE WEST BANK

In early July of 2011, I joined one of Activists for Health Equality's (AHE) weekly medical missions to the West Bank. We headed to Eilar, a small village near Tul-Karem. Its residents, we were told, possessed little access to specialized care for reasons of both affordability and accessibility, as Israeli military roadblocks and checkpoints periodically blocked access to nearby cities.

Nearly every Saturday for over two decades, AHE had been sending a handful of rotating medical practitioners to a different West Bank village or city, aiming to spread assistance as widely as possible. AHE volunteers, a mix of Israeli Jews and Palestinian citizens of Israel, included general practitioners, nurses, psychologists, pharmacologists, physical therapists, and specialists of various sub-fields, such as cardiology, ophthalmology, gynecology and endocrinology. Holding onto the seats in front of them on the bumpy mountain roads up to Eilar, practitioners in today's mission knew little about the condition of the population that awaited them. They likewise knew nothing regarding other NGOs' work in the region; instead, they were given a broad introduction to Palestinian villagers' frequent isolation from urban medical centers and told they that they would be helping to alleviate it by practicing in their respective specialties.

After two hours of bumpy mountain roads, we arrived at a local elementary school that had been converted into a makeshift medical clinic. Roughly two hundred people were waiting, assembling in noisy crowds in the school corridors and courtyard. A local Palestinian medical NGO that I shall call Crescent Relief in Palestine (CRP) had registered these patients and set

upon routing patient traffic throughout the classrooms. Following the customary ceremonial greetings and thanks by the local village head (*mukhtar*) and his assistants, the Israeli delegation rushed to divide itself into classrooms, mindful of their limited time. Once tables were pushed together to create makeshift examination beds, practitioners began examining patients and dispensing both advice and medication, as journalists from several international news agencies flitted from room to room, taking photos.

By afternoon, volunteers' high spirits began to wane. A few of the patients suffered from conditions that were fairly straight-forward to address in a few hours. One teenager, for example, had a cyst removed onsite, while others were given a month's supply of medication to tide them over until they could access more. But no follow-up structure had been put in place for keeping track of patients later on, or for providing them with additional care. This was classic one-shot medicine, which, for chronic patients in particular, posed an important problem.

For example, the mission had arrived with a van full of medication. An Israeli endocrinologist assessed several diabetic patients and handed them insulin. As a photographer clicked away, he handed one mother a month's supply of insulin for her young diabetic son, and cautioned her not to dilute the insulin to make it last longer. "They often do this because they don't have enough and can't afford more," he turned around to face me, "but diluted insulin is dangerous." Later, chuckling morosely, he asked, "how can I make sure she doesn't dilute it if I don't see her again?"

Other practitioners were similarly frustrated to learn that many of their chronic patients could not say what medications they were already taking. We cannot prescribe new medication to patients without knowing their history and current medications, one physician explained to me. "What are you taking?" she asked a middle-aged woman through a translator. The

translator repeated the question in Arabic, and the response came: “Small white pills.” The practitioner emitted a noise that was half chuckle, half exclamation. “They are *all* small white pills, aren’t they?” she shook her head, her gaze briefly locked with her patient’s. “Presumably,” she said, “I’m not the only doctor this woman will see.” Other NGOs visited this village periodically, and government doctors held weekly clinics. But who knew, the practitioner added, when this woman would see a doctor again, or what would be the status of her health the next time she did.

In another room, an ophthalmologist told the parents of an 8 year old boy, whose vision had long been severely impaired, that he suffered from a rare form of strabismus. When the parents anxiously asked what could be done, she quietly explained, via translators, that it was too late to improve his eyesight meaningfully with surgery. Has he been treated at a few months of age, she said, his prospects would have been excellent. “Where were the doctors during this boy’s infancy?” She exclaimed after the family had left the room. Her sense of futility was highlighted in an ironic way when a photographer abruptly entered the room, clicking away. Turning to her next patient, the ophthalmologist said to an assistant, “Can we turn off the light for a moment? I need to examine his eye.” The photographer interrupted, “But I need light for the photos.” The ophthalmologist lost her temper. “Who’s more important,” she snapped at the photographer, “me or you?”

The frustration of these practitioners contrasted not only with the cheerfulness of the journalists, but also with the behavior of the mission’s donors on this particular day. A German NGO had funded much of this mission, and today, several of its representatives joined the team, accompanied by with their own photographer and journalist. Peeping quickly into the treatment classrooms, these representatives, I noticed, did not stop to observe treatments or to speak to

practitioners or patients. Instead, they followed the village mayor and the team heads from AHE and CRP up and down the corridors, listening to their depictions of Israeli-Palestinian partnership. From their glowing expressions, I gathered that the misgivings of practitioners regarding patients not bringing their medication from home did not make it into their conversations.

Later on, in the van on the way home, several practitioners confirmed that no donor representatives had approached them. None of them appeared euphoric about the day that had just ended; most, rather, were in a quiet and contemplative mood. They spent the ride home mostly in silence or in quiet, intermittent conversation with each other, glumly pondering the net benefits of their visit. One of them asked an AHE staff member sitting up front what the chronic patients would do now in the absence of medical follow-up or steady supplies of insulin. The question was posed casually, but a heavy air hung in the van.

Earlier, during an elaborate feast the village had prepared to thank the visitors, I sat at the donor representatives' table. We made polite small talk in English, and they emphasized how inspiring and illuminating this day had been so far. I briefly commented on the pills-from-home issue, expecting them to react with some mild concern or curiosity, and hoping this would spark a discussion about the pills. But their inscrutable expressions betrayed no interest in my comment, and jovial small talk quickly resumed.

For a long time, I struggled with what to make of these donor representatives' seemingly unperturbed reaction. There were numerous, glaring problems with how events had unfolded that day. Some involved easily avoidable glitches: for example, only a fraction of the patients who wished to see a practitioner had been registered, and patients had not been told to bring their medication from home. At the same time, deeper questions arose regarding AHE's unintentional

contribution to the West Bank's healthcare deficit by helping prevent its crises from erupting into full-blown catastrophe. AHE, it should be noted, did not callously abandon seriously ill patients after just one meeting. Some of them were referred through AHE to specialists and hospitals within Israel. If a specialist was found, AHE then commenced to negotiate the patients' entry into Israel with the IDF and other Israeli security forces. Patients who were approved for entry then had to find the means of paying for the treatment, whether through charitable donations or the Palestinian Authority. Some were successful, but overall, only a small fraction of patients could be aided this way.

I was naive to think that donor representatives would discuss such matters – and failures – with a total stranger during the village's thank-you lunch. Did they learn of these problems, I wondered, and if so, did they report them back to their supervisors? If they did not report them, was it because they were determined to report only good news, or were there more complex motives at stake?

THE HALF-HEARTED AUDITOR

Aid scholars who write about the indeterminacy of aid practice tend to take it for granted that donors and managers at the core (e.g., NGO headquarters) know relatively little about the periphery, and that they are less critical of logframes than are frontline aid workers. David Mosse (2005), for example, argues that practice largely drives policy, rather than the other ways around. In his work, a clear knowledge asymmetry emerges between frontline practitioners and donors, and he assigns the latter little reflexivity or insight concerning this moral hazard.

In a report prepared for the Swedish International Development Agency, however, Oliver Bakewell and Anne Garbutt (2005, p. 6) present a more complex hierarchy of awareness. As they put it,

there is a hierarchy of attitudes – managers dealing with multiple projects like the logical framework as a useful summary to help simplify the complexity they face. However, those closer to the messy realities of development are less convinced. At times the manager in an NGO might like to receive logical frameworks from their partners (making life easier) at the same time as resenting the imposition of the [logframe approach] by their own donor.

As Bakewell and Garbutt (2005) argue, donors and managers need to simplify – an argument that echoes Bowker and Star’s (1999) description of classifications as a form of intentional forgetting. In this view, aid actors realize that logframes omit information, but they also know that some sort of simplification is necessary in order to understand and govern aid projects. The closer one is to the front lines, Bakewell and Garbutt (2005) suggest, the more disturbed they are likely to be by such omissions, as Anica Kos’ (2008) aforementioned disagreement with Tol and Jordans (2008) illustrates. But interestingly, Bakewell and Garbutt (2005) note, aid actors who exist somewhere between the core and periphery – that is, most aid actors – can often simultaneously appreciate the necessity of logframes while being frustrated by their over-simplifications.

Just as Janice Stein (2008) argues that new language of humanitarian accountability language should not be taken for granted as a reflection of practice, I believe it is important to not presume that logframe-oriented policy documents are accompanied by equally rigid donors and policy makers. Rather, it is necessary to examine how these actors understand logframes, and to consider the possibility that they may sometimes be as constrained by managerial principles as are frontline aid workers. They may sometimes endorse logframes, in other words, not because they are ardent devotees of rationalization, as critics assume, but because they realize some kind of accounting mechanism is necessary, and that logframes “provide easily digestible points to make the case for funding” (Bakewell & Garbutt, 2005, p. 6).

To my knowledge, the reflexivity of donors about the limits of managerialism has not yet been singled out for a focused academic study. It can, however, be inferred from numerous aid white papers and policy documents, as I have suggested with respect to the IASC guidelines in the previous chapter. For example, one USAID best practices handbook notes that, “in [our] development work... we almost never have total control over the results we seek to accomplish. Indeed, development results that would be within our control are not likely to represent sustainable development” (cited in Jones, 2006, p. 14).

Donors and policy makers’ own reservations about logframes has also been adumbrated in numerous vignettes within broader studies of aid governance. Rosalind Eyben (2011), an aid worker and scholar, recalls being asked by a donor to revise a logframe by quantifying the intervention’s chief object. As it happened, this object was itself a policy, and Eyben did not think policies could be codified as a “bounded, quantifiable entity” (p. 20). Yet when she attempted to explain this to an official representing the donor, he wrote back simply, “Please complete the matrix in accordance with the guidance” (p. 20). Furious, Eyben invented numbers to fit the requirement, only to realize that there was no one person in the funding organization at whom she could direct her anger: “it was hard to locate and therefore challenge the power over us. Indeed, I knew that many staff in that funding agency were aware that the new logframe requirement distorted what programmes like this one were trying to do. Like me, they felt powerless” (p. 20).

Managers in service bureaucracies, Hjerne et al. (2010) similarly note, are likewise often powerless to resist the dictates of managerialism: “The leeway available to managers of welfare institutions in this respect is scant. They are harnessed to implementing the dominant managerialist policy,” they argue (p. 306). Donors in India, Ebrahim (2003) observes in his

study, have grown weary with logframes, saying “we get tired of seeing reports with the first ten pages on targets” (p. 103). Curiously, however, these same donors still go on to “persistently place pressure on meeting targets, thereby implicitly equating success with target achievement” (p. 103). As Hjerne et al. (2010) and Ebrahim (2003) imply, then, donors and managers find themselves in a double bind: however critical they may be of certain manifestations of aid rationalization, they are expected or pressured to promote them. As Renuka Fernando (2012) aptly puts it, “donors need a semblance of monitoring and evaluation systems in place to appease taxpayers or larger granters. They are held accountable and must pass the buck of accountability to those they fund” (p. 6).

Such insights, I suggest, are helpful for understanding the German donors’ position on the Eilar medical day. It is possible that the German NGO’s representatives were indeed aware that not all was perfect in Eilar, or even that quite a lot was not functioning as planned. They might have also been somewhat dismayed at the apparent mishandling of money. But discussing these impressions freely or reporting them to supervisors (two very different actions) both carried important risks. First, the German NGO wanted a continued presence in Palestine, an important hotspot for international humanitarian activity, particularly in the event of a violent escalation. Donors, in other words, would likely not withdraw funds so quickly from a high-demand region even if interventions there seemed problem-prone.

There might be an important “don’t ask, don’t tell” element, then, to the representatives’ visit to Eilar. As Lipsky (1980) points out, low-level employees can carry out activities that are vital to an organization even if they seem to go against its official policy. When this is the case, it can be an advantage for supervisors not to know of it, or at least, to be able to reasonably claim ignorance of such apparent subversions. The German donor representatives, for example, likely

understood that aid work in Palestine is slow and vulnerable to ongoing regional tensions and violence, particularly when Israeli aid givers are involved. They may have felt it would be wise to not raise an immediate alarm about any seeming failures to superiors, who might thereafter be obligated to take punitive action and cut short the intervention in its infancy. In other words, it might have seemed advisable for the representatives to only “loosely couple” the activities in Eilar with their representations in reports to supervisors (Orton & Weick, 1990).

A veteran development consultant, upon hearing the story, considered this possibility likely. “Of course the Germans were not as naïve as to think this was a great intervention,” he speculated. “They go from place to place to observe interventions – their understanding of what is ‘successful’ has been tempered by years of observation. They know that this is not the time,” he added, referring to the thank-you lunch, “to tell you their doubts. But maybe later, over beers, they’ll tell each other, ‘Oh, this intervention is useless.’”

On the other hand, he added, it is also possible that these donors saw that despite the problems, things were still improving. “In the long term, when a Palestinian state forms, they’ll want to be able to say ‘we didn’t just stand idly by when they were struggling.’ They’ll want a clean record, that they did something. For that, this intervention, despite all its problems, is good enough.” Aid is a “hallway of mirrors,” the consultant added, where any critique is magnified, and failure cannot genuinely be conceded, not without careful planning. Instead, a language of diplomacy is required, wherein rationality and improvement are ever-emphasized. Donor representatives, he argued, were just as constrained by this language as NGOs. They were not in any sense “free” to share their true thoughts with a stranger while on the job.

This example highlights the complexity of assessing of aid efficacy. Alongside short-term funding contracts cutting interventions short, and expectations of quantification discounting

benefits that cannot be measured (Kos, 2008), we also find examples showing that aid efficacy is construed and assessed in more subtle ways than logframes would suggest. As the development consultant suggested with respect to Eilar, there are numerous interests embedded in an intervention, and it is possible that practitioners on all sides wished to remain in the region and were more inclined to take a long view of efficacy. Interventions are examined within their historical contexts: as the German NGO representatives knew, there was much to know about the delicate context of Palestinian healthcare and its humanitarian presence in order to understand how interventions conducted there would be received locally. Impacts were compared with conditions at the time and with those prior to the intervention.

In order to develop this point, I would like to first take up, once again, Richard Rottenburg's (2009) ethnography of development aid in sub-Saharan Africa. Rottenburg devotes himself to understanding how problems of trust are resolved among European donors, consultants, NGOs, and aid recipients. The formal solution to such problems, Rottenburg shows, typically hinges upon the quantification of aid information and its transfer from the frontlines to the donors. But such processes of rationalization are far from complete.

Rottenburg focuses on a fictionalized European development bank and its efforts to build a reliable waterworks system in a sub-Saharan country. Donors, consultants, and local NGOs often find themselves at cross-purposes: donors seek accurate information from the front lines. But frontline offices, employees and recipients are frequently not able or not motivated to provide such information, whether because it opposes their interests or because they have been reared in bureaucratic systems undergirded by a different set of implied rules, where pay is uncertain and patrimonial connections are obligatory.

One might expect, under such circumstances, that donors will seek to establish tighter control mechanisms in order to compensate for their own information deficit. But this is difficult to do, and donors know this well. Few in the development world, he writes, genuinely “regard bureaucratic organizations as rational systems oriented around the pursuit of a specific objective” (p. 15). Rather, most privately see them “as open systems [consisting] of a myriad of shifting interest groups that continually renegotiate their aims” (ibid). At the same time, aid actors know well that “from a legal and policy standpoint [it] certainly must remain the case that formally organized practices can be controlled, assessed and predicted” (ibid).

There are two contradictions, then, with which donors must grapple. First, when European development agencies offer money, technology and expertise to sub-Saharan countries, there will necessarily be an uncomfortable tension between Eurocentric narratives of technical progress and narratives of participation and self-determination. A second contradiction is between efficacy and rationality. For Rottenburg, what is “rational” in a bureaucratic sense may ironically not always be the most efficient – as I illustrated in the introduction with examples of social workers grappling with six or seven data collection systems at once (Burton & van den Broek, 2009). Donors and NGOs often realize that in the developing world, engaging in patrimonial relations, cutting corners and adapting quickly to situations at hand is usually the most efficacious, or even the only, way to get things done. However, they realize such actions would conflict with their own pre-determined policies. That is to say, in Krueger and Sagmeister’s (2014) terms, the “culture of urgency” undermines the “culture of evaluation” (p. 62).

Since donors cannot discard policy formally, they may have no choice but to occasionally subvert their own rules in order to transfer the aid to those that need it most – be it food,

agricultural technology, expertise, or medical services. David Mosse (2005), for instance, describes how donors struggle to empower local civil society actors while still having to maintain nominal control. Citing a case in Bolivia (Eyben & Leon, 2005) involving a UK-led development project, Mosse notes that “the donor had constantly to break the very rules of the game they had established, by supporting civil society projects without appearing to do so” (2005, p. 19).

Donors in Rottenburg’s (2009) narrative know it is in their interest to partially uncouple, or only loosely couple, practice from policy. For example, in the case of the waterworks project, donors habitually must concede to local demands that on paper would appear unseemly or even corrupt. Such concessions are necessary to build trust with local actors, even if they do not conform to new public management dictates. These are, for this reason, not always acknowledged in official memos. Instead, donors and managers rely heavily on “ritual evaluation” that focuses on trivial aspects of a project in order to prevent the whole project from coming under debilitating scrutiny – a point similar to Power’s (1997). Rottenburg is careful to note, however, that rationality is not a complete mirage: to prevent aid projects from collapsing, some accurate representation, we must assume, should be on hand at all times. These are not, in other words, “Potemkin village facades” or “false messages” that aid actors typically convey to one another; rather, they are “condensed ones” (2009, p. 70).⁴⁸

Loose coupling and ceremonial representations do carry important risks. They may result, as Rottenburg notes, in “structural myopia and institutional amnesia” (p. 71). I have made a similar point regarding logframes and their limited ability to make aid work visible. For example, if staff turnover is high and logframes are deliberately uninformative, then future

⁴⁸ James C. Scott (1998) also discusses Potemkin facades (p. 207).

cohorts of aid workers who arrive on site with only official reports at their disposal may not find out what had actually taken place, and what had worked and what had not. This lack of knowledge is intensified when donors “begin at some point to believe their own official representations that have in fact been produced for external consumption” (Rottenburg, 2009, p. 71). There is always the question, then, not only of to what degree logframes faithfully represent frontline aid work, but also to what degree they are believed to do so by those who write them and those who read them.

Rottenburg’s work, then, suggests that ritual evaluation is often a deliberate move, and not simply the accidental result of a misguided rationality fetish. His examples of ritual evaluation recall Meyer and Rowan’s (1977) account of loose coupling taken to an extreme, whereby “goals are made ambiguous or vacuous, and categorical ends are substituted for technical ends. Hospitals treat, not cure, patients. Schools produce students, not learning” (357). A problem with this interpretation of logframes, however, is that if assessments of efficacy are truly little more than ritual evaluations, what veracity might then remain to keep systems going and to avoid “Potemkin village” facades? Rottenburg offers little solution to this problem.

Even if rule-driven practices are not the only driver of frontline engagement, Rottenburg (2009) concludes, the language of rationality remains the obligatory metacode that distant aid actors often use to talk to each other about the work they have done; no other language is politically feasible. In the Eilar example, for instance, if donors and managers were indeed familiar with the problems onsite, their silence might not necessarily reflect self-interest or the desire to escape accountability. Rather, it might reflect an understanding that admitting failures needs to be done in careful ways and in specific venues. Such an understanding, it is true, would contradict official scripts of aid transparency and rationality; but it may be a more accurate

depiction, overall, of aid's frontstage-backstage dynamics (Hilgartner, 2002). As Rottenburg (2009) and Thomas Yarrow (2011) have argued, aid actors often understand that loose coupling is not a failure, but is rather critical for aid to succeed.

Several months after the Eilar visit, Rana, an AHE human rights worker and Palestinian citizen of Israel, supported this hypothesis while giving me a ride home from Jaffa to Jerusalem. During the trip, I told her about the Eilar visit, recounting the bungled attempts to address chronic problems and the fact that most chronic patients could not be prescribed medication, since they had not brought existing medications from home. Rana snorted, unsurprised, and said it was likely the local NGO's fault – Crescent Relief for Palestine (CRP). It was their professed responsibility, she said, to remind people to bring their medications from home, but they rarely did so. What they tended to do instead was simply announce in the local mosques and schools that foreign doctors were coming next week, and that everyone who needed a doctor should come. And on the actual medical days, they had been known, she said delicately, to neglect their duties.

I asked Rana why AHE kept working with CRP if they were so unhelpful. She responded that AHE effectively had no choice. As an Israeli aid organization closely associated with the occupiers, AHE needed a local Palestinian partner to legitimize their work, serve as a practical liaison with the local population, and give the impression of local participation with AHE's mission. There were few options besides CRP. By the way, she added with a chuckle, CRP also used AHE for their own ends by telling their local press that they were the ones administering medical aid, not AHE. The day after an intervention, local newspapers often attributed the "doctors" onsite to CRP alone. "This is the true face of Israeli-Palestinian partnership, see?" she said.

I understood then some of the myriad reasons why it was important for AHE and CRP to keep working together. Collaborations of this kind, both sides realized, were necessarily slow and friction-prone. Mindful that this was “as good as it got,” AHE and CRP kept on collaborating in this manner not simply out of self-interest or a desire for organizational survival, but also out of the realization that collaboration was critical for enabling these visits to succeed to any degree. If AHE dropped CRP as a partner, it would struggle to find an alternative local organization, and the West Bank missions might grind to a halt. Meanwhile, if CRP refused to work with AHE, it would lose critical funding and face the consternation and unmet needs of its own constituents. The more sustainable alternative to these short-term humanitarian missions, both CRP and AHE knew well, would involve working for longer-term solutions for villagers with little access to secondary and tertiary medical care. But this course of action posed daunting challenges of its own and would likely yield only few immediate solutions for patients in dire need. For these aid actors, then, brief medical missions served as the best interim solution, through the complex interplay of concessions on both their parts.

This chapter has attempted to describe some of the workings and limits of aid rationalization. As technologies of aid governance, logframes, I have argued, cannot capture or control important aspects of frontline aid work, nor do they obviate the necessity of establishing informal relations of trust among aid actors. Logframes seek to make aid subjects auditable in particular ways (Dunn, 2004), but as I illustrated, psychosocial aid workers often find way to circumvent or tweak logframe expectations. Short-term funding and negative external evaluations are less easy to circumvent, but even consultants, as I suggested, play an important aesthetic role of projecting an image of rationality. As Stirrat (2000) argues, the aesthetic

dimension weakens or comes at the expense of actual insistence of quantification and on meeting donor criteria.

Aid actors across the aid sphere, including NGO managers and donor representatives, I have suggested, are often aware of these limits of rationality, and in some senses benefit from them as they engage in complex backroom agreements (Hilgartner, 2002) to help push projects through, as I suggested with respect to the Eilar example. At the same time, the notion of “blueprint development” (Roe, 1991) continues to dominate official discourses. As Stirrat (2000, p. 36) argues, the rationalist discourse of development presumes that

this world is not just knowable but knowable in positivist, empiricist terms. Thus there is no room for interpretation because this world consists of empirically verifiable facts (e.g. how many people are ‘poor’; what are the salient ethnic identities; what is the gender division of labour). Terms which others might find problematic or questionable such as the ‘household’ or the ‘family’ or the ‘nation’ are all reified into objectivized categories.

This statement, I suggest, captures a particularly strong manifestation of the rationalization paradigm. Frontline practice, as I have shown, unfolds in more complex ways, and many aid actors are likely to be critical of the epistemological assumptions that Stirrat attributes to the aid sphere. At the same time, they must often pretend, to some degree, that they do buy into them. This creates a difficulty for the analyst in drawing out the substantive influences of logframes and other technologies of monitoring on aid work.

As Elizabeth Dunn (2004) notes with respect to the Polish baby food factory’s transformation, “capitalist accounting systems depend on the ability to make it *appear as if* the rules specify the recording of objectively existing facts to create moral as well as financial accountability” (p. 42, emphasis added). Thus, much of Dunn’s narrative – factory workers relying on long-standing patrimonial relations and agreements to resist American managers’ efforts to make their work auditable – mirrors how I have suggested that aid practices unfold.

Yet like Power (1997), Harper (2000), and Rottenburg (2009), Dunn (2004) herself also draws attention to the performativity of such auditing practices with the words “appear as if:” Dunn’s own capitalists, in other words, seem themselves aware of such performativity, putting the substance of their reforms into question.

Janice Stein (2008), as I noted in the beginning of this chapter, asks to what degree contemporary aid practice actually mirrors the new language of aid rationalization. Yet as Rottenburg’s (2009) description of loose coupling shows, there is the possibility that logframes are constructed ad-hoc to fit presumptions of rationality, with few practical changes being required in how interventions are implemented.⁴⁹ While my chapter supports this possibility to a degree, some forms of rationalization, I have shown with Kos’ (2008) critique, are not so easy to circumvent or tweak. Thus, this chapter leaves open at least two important questions. First, how might we separate practices of loose coupling that are masked with an obligatory *metacode* of rationality (Rottenburg, 2009) from any “genuine” substance or influence of aid rationalization?

A second question concerns the limits of loose coupling, and recalls Wong and Gerras’ (2015) description of deception in the military from the introduction to this dissertation. Rottenburg (2009), namely, insists that loose couplings never become total “Potemkin village façades;” some tight couplings do remain (p. 70). But what specific mechanisms are in place to ensure this and prevent such total trust breakdowns from occurring, if loose coupling is indeed ubiquitous? In other words, what, precisely, is the interplay between policy-driven and policy-subverting action?

While this question merits considerable additional research, one possibility presents itself: donors and NGOs of varying stripes change their staff frequently. In other words, new

⁴⁹ Thank you to Judith Reppy for this idea.

people, and new ideas, enter and exit aid institutions all the time, each with varying degrees of naiveté about, or belief in, the regulatory capacity of new public management (Stirrat, 2000). Thus, for every aid actor for whom aid rationality is a misguided and constraining ideology, there will be others for whom it is, for a certain time period at least, a genuine goal to strive for. By the time their own belief fades, others will come in with redoubled belief. If this is indeed the case, then “blueprint development,” while far from a faithful representation of frontline work, will never be simply a façade, either. And if this is so, then the tension between policy-driven work and improvisational work, which I have devoted this dissertation to exploring, will continue to persist.

CONCLUSION

BUREAUCRATIC ORDER AND DISORDER IN HUMANITARIAN AID

How do humanitarian organizations deliver aid in chaotic environments? What roles does discretionary action play in such work? And what are we to make of a growing humanitarian managerialism that attempts to counteract frontline discretion using quantitatively defined outputs, benchmarks, and efficacy metrics?

According to Janice Stein (2008), managerial practices of the sort this dissertation has explored constitute “an exercise in instrumental rationality that ... is largely unachievable” (p. 126). The reason, she claims, is that “[w]ar zones in the last three decades do not look much like space that is structured according to shared norms and rules. As civil wars stretched and states were made, unmade, and remade, it became more and more difficult to maintain a restrictive set of parameters for humanitarian work” (p. 129). Yet the apparent chaos of aid settings does not stop aid actors from trying to set such restrictive criteria. In concluding this dissertation, I would like to briefly revisit my arguments throughout the five chapters. I then examine my dissertation’s contributions and limitations, and offer up some suggestions for future research.

Broadly, I have argued that practices of humanitarian governance cannot, nor are they meant to, remove all that is organic and context-dependent from frontline practice. However, the ways in which diversions from disorder are tolerated are not random. Rather, there are specific spaces within the operational fabric of the aid industry in which loose coupling and improvisation are permitted to thrive (Rottenburg, 2009). I have shown that aid workers are often aware of frontline indeterminacy, and that even high-ranked actors to some degree endorse improvisation as necessary for aid work to succeed. This finding, I have argued, suggests that aid actors both high and low in the power hierarchy often regard policy as being “relational,

contested, and never-finished process” (Eyben, 2011, p. 20). In this manner, this dissertation challenges views of frontline improvisation as a mere subversion of rational intent or of strict governance tactics from above.

My purpose in this dissertation, however, is not simply to illustrate indeterminacy, but rather to show how it arises within the context of specific humanitarian projects and mandates. Chapters 1 and 2 focus on Activists for Health Equality’s (AHE) efforts to reconcile two competing mandates: humanitarian aid and human rights advocacy vis-à-vis the Israeli government on behalf of asylum seekers. In chapter 1, I illustrated the particular arrangements (*combinot*) that aid workers negotiated with practitioners and government bureaucrats in order to secure treatment for their patients. The clinic, as portrayed there, always seemed on the brink of collapse: files were misplaced, patients were periodically turned away, and the supply of volunteers and treatments was always uncertain. Yet somehow, aid work continued amidst these failures. Some of AHE’s aid-giving flaws, I suggested, could be attributed to scarce resources and limited compassion by volunteers, but not all: there was also a collective aversion to additional fundraising and volunteer recruitment that could have ameliorated some of the chaos.

In chapter 2, I explained this aversion in terms of AHE’s struggle to blend aid and advocacy. Knowing that healed patients reduced the overall crisis and undercut AHE’s political momentum, some AHE staff members sought to place limits on aid. Yet these limits, I argued, were not simply the product of conscious calculation of aid-advocacy tradeoffs: rather, there were also less calculated processes at play. Namely, some of the chaos at the clinic, I suggested, reflected a subtle attachment to an emergency imaginary (Calhoun, 2010) which framed needs as crises and legitimated immediate action in response to them, as well as a particular performance of aid on the brink. Thus, failures that still fell within this imaginary were to an extent

“forgiven” or tolerated, for they reinforced AHE’s self-image as a scrappy but valiant underdog refusing to accept governmental policies of exclusion.

There was a strong aesthetic dimension to this imaginary: part of AHE aid workers’ aversion to additional recruitment, I suggested, was an aversion to the bureaucratization of the clinic and to the hum-drum physical transformations such bureaucratization would entail, as the section about Yaniv’s gleaming new governmental clinic illustrated. Bureaucratization also required setting explicit patient quotas and professing AHE’s treatment limits more explicitly – a form of rationalization that aid workers feared would turn them into indifferent service providers rather than compassionate volunteers. As I suggested, bureaucratization and quotas posed an important threat to AHE’s ideals of unconditionality, an important core tenet in the humanitarian repertoire.

Taken together, these two chapters complicate popular assumptions about what aid looks like. First, if it seems intuitively reasonable that dedicated aid workers would want to give their beneficiaries as much medical assistance as they can, and that they would stop only when they ran out of resources, then these chapters provide a corrective to this assumption, illustrating the more complex priorities that co-exist in daily aid practice. A second complication concerns the appearance of failure, discretion and disorder in frontline aid practice. While we might think of habitually misplaced patient files as a serious destabilization of humanitarian work, appearances of disorder and failure can, as I have shown, prop up an NGO through appeals to popular imaginaries of emergency.

To some observers, it may seem ironic that an aid organization otherwise tirelessly devoted to lifesaving might romanticize some of its own failures to save lives. Yet this is precisely what happened at AHE, even if the tireless life-savers were usually not those who

explicitly justified aid limits or rationalized misplaced files. Rather, the clash of priorities and imaginaries of assistance manifested, I argued, in a more subtle organizational ambivalence, exposing the complex agendas that underlay seemingly simple mandates to give assistance. Namely, I suggested that the understaffing and misplacing of files persisted due to a combination of deliberate and non-deliberate elements: some aid workers rationalized failures by referencing the Israeli government's ultimate responsibility in the matter or by pointing to the need to maintain an advocacy momentum. But for other staff members, like Nofar the administrator, the appearance of chaos itself became unconsciously normalized as what "real" aid should look like, subtly legitimizing AHE's faults and prolonging organizational indecision regarding seemingly simple matters such as whether to put another volunteer at the door.

The two AHE chapters, while offering numerous examples of frontline aid practices, reveal little about the broader context of aid governance, or specifically, how failures of the sort that arose at AHE might be handled if they happened at an NGO with more explicit or rigid expectations of order, or with a stern overseer from afar. Chapters 3 and 4, then, scaled up to address these broader questions with respect to humanitarian mental health, illustrating the difficulties of writing and implementing policy in a humanitarian subfield whose boundaries are highly contested and fuzzily drawn.

The archetype of parachuting psychologists, I argued, evokes the ire of aid practitioners and critics for two very different reasons. On the one hand, parachuters anger aid skeptics by recalling the stereotype of the arrogant, ignorant and sanctimonious Westerner, flying in to bestow her superior knowledge and wealth upon populations that do not desire or need it. At the same time, however, parachuters elicit opposing concerns by aid instrumentalists who fear that the wide-open field gives non-professionals free rein to practice whatever interventions they

desire under a guise of expertise. Operating far from scrutinizing eyes or efficacy tests, those practitioners appear to elude governance and quality control.

While both aid skeptics and aid rationalists worry about parachuters' impact on aid recipients, then, they place different emphases upon what they believe is at fault. Thus, when the IASC guidelines were published in 2007, their authors sought to please both camps of critics, I have argued, by straining in two markedly different directions of reform: rationalization through a more precise articulation of impacts and effects (to satisfy the rationalists) and sustainability (to assure skeptics that the field was moving in the direction of recipient-driven, holism, long-lasting interventions). These two reforms, I suggested in chapters 4 and 5, have tended to undermine each other: for example, the "rigorous assessments" and "evidence-based" interventions of the rationalization mandate tend to privilege narrow interventions whose efficacy can be quickly measured at the expense of broader, community-wide interventions. Moreover, references to evidence-based interventions pit science-based expertise with the tacit knowledge of long-term practitioners like Marika and Larena.

Curiously, the rationalization mandate, while frequently invoked, is nowhere precisely articulated in the guidelines or its dissemination documents (van Ommeren et al., 2005). As I illustrated, references to evidence, science, and rigor are kept productively vague, implying that they are meant, or the time being at least, more as appeals to rationality and modernity than as articulations of particular studies or techniques (my informants' own uses of the term "evidence" yielded similar impressions). For a document that purports to inject clarity into a contested and beleaguered field, moreover, the guidelines ironically contain very few guidelines: their prescriptions for practice remain exceedingly broad, even by the lax standard of UN white papers. In chapter 4, I addressed this ambiguity by illustrating how and why psychosocial aid

and humanitarian mental health become difficult to define and police in daily practice. Ambiguous terms like “counselor,” for example, permit frontliners considerable discretionary power (for example, in hiring locals to do aid work who otherwise would be barred due to absent credentials), but such broad terms also carry the stigma of uncertain expertise.

The guidelines, I argued in chapter 4, contain two important omissions. First, no mention is made of donors’ penchant for short-term aid grants. The guidelines thereby imply that sustainable interventions hinge largely on which methods are chosen, rather than how much money is available to enact them. A second omission concerns the politics of sustainability and of mental healthcare in non-Western settings. By remaining judiciously silent on which techniques should be enacted in the field or which forms of expertise should nourish them, the guidelines thereby successfully sidestep thorny debates regarding whether psychotherapy is appropriate in cultures where talking about the dead is taboo, as Larena’s story illustrated. Yet such debates matter immensely to aid workers, I have argued.

For example, the notion of sustainability is considerably more contested and complex in practice than the guidelines discourse appears to presume. What seems sustainable or recipient-driven on paper, for instance, does not always capture the desires of recipients, as I illustrated with respect to the Eritrean mother who sought food and the psychosocial NGO’s fizzled meeting with the asylum seekers. In addition, some seemingly sustainable interventions, like the movement for global mental health’s efforts to scale up mental health services in developing countries, can still rely upon narrow biomedical conceptions of mental health.

Thus, while the guidelines imply that interventions that aim to be sustainable are also those that work in favor of locals, who presumably themselves want long-term impacts, stories from the field suggest that recipient-driven aid and sustainable aid are not necessarily the same

thing – and both are, to a degree, performative and self-serving postures conjured by the humanitarian industry itself. The guidelines’ omission of the politics of sustainability and funding, I concluded, amounts to an anti-political argument, implying that good aid is purely a matter of method and expertise, rather than of politics and economics.

A similarly anti-political space, I have argued in chapter 5, is created by logframes. With their presumption of a linear causal relationship from inputs to impacts, logframes not only tend to imply that aid actors agree on who the beneficiaries are and what a project’s goals are (which is often not the case), but also devalue interventions that cannot be measured or quantified. The way logframes “see” the human landscape thus captures well the idea of coproduction (Jasanoff, 2004ab): logframes, namely, presume that aid interventions can be broken down into discrete, specifiable components, but in doing so, they also gradually remake the aid sphere to fit this image by serving as increasingly obligatory tools of governance by donors and NGOs.

Yet managerialism is only imperfectly implemented in the field. As Kos’ (2008) critique of quantitative psychosocial evaluation has shown, some forms of managerialism pose hard forms of control. But others do not: some of my informants reported being able to tweak and circumvent logframes with ease by changing project descriptions, and further intimated that donors were not as zealously devoted to rationalization as they professed to be. In the final section of chapter 5, I explored this possibility myself with a vignette depicting a fraught and reflexive encounter between German donor representatives and Israeli and Palestinian staff members of the funded NGOs. Drawing upon literatures on audit and loose coupling, I suggested that not only frontline aid workers, but also aid actors higher in the humanitarian hierarchy, possess an important awareness of the indeterminacy of frontline practice and of the need to permit this indeterminacy to thrive in patently non-rational ways.

CONTRIBUTIONS

This dissertation undertakes to make several main contributions. First, it aims to add to the ethnographic literature on humanitarian assistance (Abramowitz & Panter-Brick, 2015; Fernando & Hilhorst, 2006; Lewis & Mosse, 2006; Redfield, 2005, 2010, 2012a, 2013; Redfield & Bornstein, 2010). As Udan Fernando and Dorothea Hilhorst (2006) note, a lot of the literature on aid is not ethnographic, and does not explicitly seek the view from the front lines. Therefore, numerous studies are prone to sweeping and dichotomous statements that tend to either idealize or demonize aid.

Aiming to depart from such portrayals, I have attempted to draw out the complexity and ambivalence of decision-making in the front lines. For example, AHE aid workers, I have emphasized, do not fall into rigid patterns of *either* demanding more aid *or* callously rationalizing aid failures as a function of scarce resources or governmental neglect. Rather, as I have shown, they all grapple uneasily with competing priorities, including some – like attachments to notions of emergency – that operate on less-than-conscious levels. And with respect to psychosocial aid actors, I have likewise attempted to show that donors are more critical of rationalization, and frontline practitioners are more self-conscious about their own cultural baggage, than their critics tend to assume.

I have also attempted to make some more specific contributions. First, while several aid scholars have described in detail the fraught relationship of NGOs to states (Abramowitz, 2015; Filc, 2009; Gottlieb et al., 2012; Ticktin, 2006; Willen, 2011, 2012), none, to my knowledge, have attempted a sustained engagement with NGOs that criticize a government while at the same time quietly collaborating with its low-level bureaucrats in order to obtain treatments for

patients.⁵⁰ By showing how AHE aid workers cultivate such relationships in order to work the margins of the state's medical bureaucracy, I aim to complicate the distinction between official and unofficial channels of care.

Second, I have attempted to build on Peter Redfield's (2010, 2013) important analysis of verges of crisis. Redfield argues that contrary to popular assumptions, most humanitarian actors operate not in zones of "emergency" but rather on verges of crisis, a position they often find discomfiting since it lacks the expected moral clarity (however misleading it may be) regarding who is most in need of help. Indeed, as Calhoun (2010) observes, many aid organizations actively seek zones of emergency or are tempted to view ambiguous needs as emergencies for this very reason.

By depicting AHE aid workers as they grapple with the ethics of helping a "rich" refugee, or ask whether or not a lack of privacy is a "normal" state for asylum seekers, I have attempted not only to provide further evidence for Redfield's (2010, 2013) and Calhoun's (2010) arguments, but also to show that questions about normality and emergency are inextricably bound up with the politics of postcoloniality. For example, Meirav, in asking whether her asylum-seeking patients truly need privacy, or whether what they have at AHE is still not infinitely better than they would have gotten back home, is thereby posing a question about what counts as normal for patients. She is apportioning normality differentially while positioning her beneficiaries and herself along an imagined global spectrum of wealth and scarcity.

⁵⁰ File (2009) does address some of the Israeli government's cost-containment-driven generosity towards non-citizens in his work, but he does not spend time on NGO-governmental arrangements, although he is well-aware of them. Sarah Willen (2011, 2012) and Heide Castañeda (2010) have done excellent work on undocumented migrants and humanitarian medicine in Israel and Germany, respectively, but neither of them focuses in particular on state-non-state collaborations behind the scenes. Finally, Sarah Horton (2006) shows how American doctors subvert insurance regulations to help patients, but her main focus is a critique of US healthcare.

A related contribution pertains more broadly to the politics of humanitarianism. Aid scholars have long been interested in the ways in which aid can come at the expense of political redemption by distracting from systemic inequalities or depriving aid recipients of political agency (Fassin, 2007ab; Feldman, 2009; Ticktin, 2006, 2011). My chapters on AHE, and to a lesser degree, chapter 3 on the parachuting archetype, have shown not only how aid can come to serve in an anti-political capacity, but also how aid workers themselves articulate their own regrets and reservations about contributing to such realities.

While AHE may seem different than other aid NGOs by virtue of its declaration of a second, human rights mandate that clashes rather dramatically with the first, all aid organizations, I suggested, struggle to articulate their responsibilities to their beneficiaries and to define their own aid limits. AHE's halting efforts at mandate reconciliation – or more accurately, its vacillating *non*-reconciliation – yields important insights about the predicament of humanitarianism at large by exemplifying its persistent attachment to ideals of unconditionality and transcendence, which are increasingly at odds with the political constraints and bureaucratic banalities of daily aid practice (Barnett, 2005; Barnett & Weiss, 2008).

At the same time, I have suggested, aid workers do not uniformly embrace aid unconditionality, or embrace it in theory but not in practice. As several of my ethnographic examples illustrate, AHE aid workers often jump back from the notion that everyone deserves healthcare to a more limited gift logic that ranks recipients by degrees of deserving, and often expects some form of gratitude or acknowledgement from them, in return. The aid workers who balked at the fat wallet; the outreach director who insisted that aid recipients should know that AHE is an NGO; and the young volunteer who railed against the “sense of entitlement” of the patient whose file had been misplaced, all demonstrated that despite a strong attachment to ideals

of unconditionality, humanitarian assistance and human rights advocacy are irreducibly preoccupied with questions of conditional worth.

The final and perhaps most important contribution of this dissertation concerns notions of disorder and order. Here, I have drawn on both audit and loose coupling literatures (Harper, 2000; Meyer & Rowan, 1976; Orton & Weick, 1990; Power, 1997; Rottenburg, 2009; Strathern, 2000) and on STS literatures on the political lubrication that is accomplished by acts of quantification and classification (Bowker & Star, 1999; Downer, 2012; Jasanoff, 2004ab, Porter, 1995). Chapters 4 and 5 illustrate how technologies of rationalization strive to make aid workers auditable by dividing up aid work into discrete, measurable components. I have also analyzed the ways in which such technologies are resisted and critiqued, both by aid workers keenly attuned to the ambiguities of frontline practice (such as those who tweak logframes to fit diverse requirements) and by supervisors and donors who are more reflexive and half-hearted in their auditing than they may seem. The humanitarian sphere's capacity for critiquing humanitarian managerialism, I have argued, is not only the provenance of frontline practitioners or critical outsiders, but is rather widely distributed throughout the field itself.

The auditory lacunae present in aid infrastructures – the kind which permit frontline aid workers to give more aid than they are officially mandated to, and psychosocial project managers to hire practitioners lacking required accreditations by calling them “counselors” – has moderated the rush to humanitarian rationalism. Crucial to maintaining such flexibility has been the notion of the public secret. As Taussig (1999) puts it, a public secret involves information that many actors know about, but cannot, or feel that it would be ill-advised to, articulate in public settings or before certain audiences.

P.W. Geissler (2013), drawing upon Taussig's work, suggests that public secrets are vital to both sustaining organizations and creating knowledge. For example, they make certain partnerships possible that otherwise could not exist. Geissler focuses in particular on transnational public health research collaborations between universities and researchers in sub-Saharan Africa and in the global north. For wealthy northern universities, he shows, local partnerships are crucial to gaining access to desired research subjects and acquiring local credibility, connections, and a semblance of authenticity. For local partners, meanwhile, these partnerships hold the promise of funding, local health improvements, and global citizenship and recognition. Yet deep inequalities in intellectual credit and resources continue to pervade these partnerships in the guise of inclusion and partnership, inequalities that are typically known by all involved but which "often remain unacknowledged in public speech and scientific texts" (p. 13).

Geissler reads these silences not as active suppressions, as might be expected, but rather as strategic silences in the presence of particular audiences that are relaxed in front of more trusted, close colleagues. Being openly critical of the fundamental inequalities that undergird these partnerships could endanger them. As Geissler describes, in the absence of models for how to act and distribute intellectual credit and funds in a genuinely equitable way, actors on all sides muddle through the existing infrastructures of power in the best ways they can, well-aware of the fact that they are reaping unequal benefit, while attempting to convince themselves that the status quo is still better than no collaboration at all. In such contexts, knowing when to be quiet and when to be candid becomes a vital skill that organizational actors have to learn in order to maintain the present or advance desired goals.

In the case of AHE, too, it was important for aid workers to make sure that certain hospital discounts for asylum seekers did not become widely known, as this could evoke

unfavorable bureaucratic scrutiny by hospital administrators and thereby endanger these funds. It was considered permissible to speak of these discounts at the clinic among trusted volunteers, and even with certain allies in local hospitals. But in broader venues, the official story was one of separate governmental and non-governmental spheres, with no ostensible collaboration between them. However inaccurate, it was a story that both sides had an interest in maintaining: the Ministry of Health, for its part, sought to avoid a public image of excessive or undue generosity towards a non-tax-paying population of migrants; while AHE had an interest in keeping up appearances of an underdog fighting ceaselessly for policy change, instead of collaborating with, and thus indirectly bolstering, the very state bodies it was opposing.

Aid workers did periodically break unspoken bonds of silence by revealing some of AHE's internal flaws to distant actors who might otherwise be expected to be kept in the dark about such matters. For instance, as I described in chapter 1, Rebecca, the clinic manager, wrote candidly in a report to a donor of the difficulty of providing high-quality care to patients at AHE given the high turnover of volunteers. Such arguably unflattering information, which revealed some of the daily chaos going on at the clinic, suggested that the question of which information is habitually disclosed to or concealed from which actor cannot not be easily predicted based on broad pre-existing alliances. It is possible that such candor was a slipup on Rebecca's part, but it may have also been strategically done in order to convey the kind of complexity that this particular donor was expecting to receive from a trusted organization that it knew to be operating in a challenging aid environment. Giving an overly smooth portrayal might have been received with suspicion.

The social life of secrets, then, appears indeterminate and contextually dependent. Scholars concur that the production of ignorance serves diverse organization purposes, and is

driven by multiple actors, and not merely from above (Geissler, 2013; Knudsen, 2011; Proctor & Schiebinger, 2008). Institutionally, the “creative side of unknowing,” as Geissler (2013) puts it, can serve to silence or replace dissent and critique, thereby maintaining existing power hierarchies by reinforcing the existing social order. At the same time, some public secrets can disrupt existing social orders by working against inequalities under the radar, as the case of AHE and the hospital discounts would appear to illustrate (although another reading would see such discounts as indirectly helping to maintain the exclusion of asylum seekers from governmental healthcare plans).

Studies of ignorance and unknowing have increasingly attempted to explore the varied manifestations and consequences of public ignorance. As Morten Knudsen (2011) notes, some of these manifestations appear to be the consequence of limited distributed cognition throughout an organization: “social systems are always non-transparent to themselves and also to others. A system cannot produce a complete description of itself” (p. 965). At the same time, another form of organizational blindness would appear to consist of a deliberate inattentiveness, Knudsen argues, whereby troubling or problematic “information is actively ignored or kept out of sight” (p. 963). Both types of ignorance, as I have shown in my discussion of loose coupling (Rottenburg, 2009), exist in abundance in the aid sphere, and they deserve further exploration.

Concerns with disorder unite the two halves of the dissertation. The first two chapters emphasize the organic emergence of indeterminacy, illustrating the daily contingencies that impinge upon aid workers, and showing how improvisation becomes a necessary response to them. I also illustrate how the appearance of disorder and even failure can itself acquire an important aesthetic value that helps to perpetuate these realities. Then, the remaining three chapters illustrate efforts to minimize indeterminacy from afar through policymaking and

technologies of inscription. As I have shown, these technologies of inscription are used in ways that gradually alter which interventions are considered legitimate, capturing the essence of co-production of knowledge and order (Jasanoff, 2004ab). For example, psychosocial day camps are easier to run on a 9-month grant that requires short-term quantitative indicators of success, than is the construction of a mental health center, which may stumble at numerous stages, from the politics of acquiring a building approval to the delicate task of recruiting staff without official credentials.

Yet logframes and other tools of inscription are far from being foolproof means of governance. First, they are often based on self-reports that, tight auditory rhetoric aside, are difficult to verify from afar, as I illustrated at the very beginning of the dissertation; second, they are often tweakable; third, their core concepts – notions of evidence and rigor – are vaguely articulated in aid policy documents; and fourth, the actors who enforce them do not always do so religiously (Ebrahim, 2003; Mosse, 2004; Rottenburg, 2009). As I have argued, a diffusion of quiet doubt permeates discourses of rationalization throughout the aid sphere. As Rottenburg (2009), Eyben (2011), and Ebrahim (2003) have shown, even donors themselves may share this doubt, feeling at times constrained to abide by managerial principles themselves.

The 2007 IASC guidelines are a good place to examine this diffusion of doubt. In chapter 5, Larena notes that her supervisees' worries about whether domestic violence in the West Bank is an occupation-related problem or an older social ill would never make it into a logframe. There is considerable space, in other words, for discretionary action in the psychosocial front lines, since logframes tap particular kinds of information and not others. When we consider how the IASC guidelines were written, this is not surprising. Indeed, the guidelines are so broad and lacking in specific directives that it seems difficult to call the

guidelines a policy document: its breadth and generality reads more like a bland endorsement of holism, sustainability, and rationalism that scarcely specifies what these terms might mean.

This breadth can be read, I suggest, in two different ways: first, the broad language of the guidelines, combined with the diverse backgrounds of the writing committee, can be interpreted to mean that the authors were aware of the difficulties of attempting to govern frontline practice from afar, particularly for such a diverse field, and sought to write the policy as loosely as possible in order to legitimate giving frontline practitioners some discretionary power. But another interpretation, as I noted in chapter 4, would refrain from jumping to conclusions about the writing committee's intentions and instead read the guidelines in a more circumspect manner as an oblique diplomatic document that says little about how aid is or should be governed. The latter interpretation, I concede, would render problematic my efforts to present the guidelines as a form of aid governance.

Studies of order and disorder carry risks of polarization: they can either conclude that every aspect of social life is messy and improvised (for which they will likely find considerable evidence), or instead, claim with a Foucauldian (1988) fervor that technologies of governance remake their subjects into self-governing pawns who are largely deprived of their agency without being aware of it. Locating and persuasively arguing for a middle ground is no easy task, and I have only begun to scratch the surface of such a portrayal in this dissertation.

LIMITATIONS

Barriers to ethnographic access made some of the central questions of this dissertation difficult to explore. I was often unsuccessful in getting donor representatives and high-ranking NGO staff to speak with me about their work. As a result, I often had to infer their views about

rationality and aid governance from secondary literature and from a limited number of interviews and ethnographic encounters.

While I was not surprised that donors and NGOs would protect themselves from unwanted intrusions or criticism, my limited access to these actors necessitated some complex compromises. For example, the Eilar vignette in chapter 5 contains speculations about the German donors' understandings from a development consultant, who, despite having worked with donors for decades, was not a donor. Similarly, my analysis of policymaking in the psychosocial sphere is limited by the fact that I had little access to policymakers who could yield rich insider information about how and why the guidelines were written the way they were. In chapters 3 and 4, I attribute some of the guidelines' generality and absence of particular directives to their authors' reflexivity about frontline indeterminacy, but I am aware that this inference is problematic and provisional given my limited ethnographic access, as well as the limited material available elsewhere.⁵¹

I focus throughout the dissertation on how aid actors think about bureaucratic order and how they attempt to both instill and subvert it. But I was able to gain only modest access to those at the top who were doing most of the governing: policy makers, mission heads, and donors (a rather reclusive and elite group). The structure of my dissertation, therefore, became somewhat lopsided, like a lion's head (psychosocial governance) attached to a zebra's body (frontline medical practice). The dissertation's ethnographic centerpiece is a small medical NGO in Israel, and I spend a lot of time describing its aid work as it unfolds in the front lines. But there was little possibility of reaching out to AHE's donors for comment on how they felt about AHE's wrenching debates about how to balance aid and advocacy. Even if I were somehow able

⁵¹ See footnote 38.

to acquire such access to their donors, asking an NGO about its donors or seeking to contact them directly is a delicate business that can, in some cases, deeply violate aid workers' trust. For example, Tom, AHE's executive director, asked me not to speak with hospital administrators about the lines of credit they had consented to give asylum seekers, for fear that my questions would trigger unwanted scrutiny.

Questions concerning representativeness constitute the final limitation that I will address. AHE places significant emphasis on both aid and advocacy simultaneously, instead of identifying chiefly with one or the other. This, coupled with its particular geographic location, appear to limit broader insights that might be derived from its particular handling of ethical and logistical dilemmas of aid-giving. Nevertheless, I have suggested that even NGOs that do not declare an explicit human rights agenda to serve as a check on their humanitarian work will still wrestle with similar ethical dilemmas regarding their obligations to their recipients, and in particular, the risk of doing local populations harm in the long run with the provision of immediate help that unintentionally prolongs a struggling status quo. What does seem important to mention, however, is the temporal contingency of a study like this one. I was fortunate, in an ethnographic sense, to come upon AHE at a particular time in 2011 and 2012 when the number of asylum seekers crossing the Sinai border into Israel was growing rapidly. During that period, thousands of stateless patients clamored for medical aid that the local state would not give them, propelling AHE into a series of seemingly interminable ethical dilemmas: how could a small human rights organization handle tens, or even hundreds, of thousands of patients without accepting Israeli government funding to do so, or without having to recruit so many additional volunteers and funds that it began to resemble a government clinic, instead of an aid organization?

Only months after I left Israel, the Israeli state completed the construction of a fence along the Egypt/Israel border. To the surprise of numerous AHE aid workers, who had insisted that asylum seekers would find another way to enter the country, the steady stream of migrants entering through the Sinai desert did decrease to a trickle, or around 10 individuals per month by 2014 (Omer-Man, 2014). Meanwhile, the Israeli government initiated stricter measures to detain and deport thousands of asylum seekers (Kestler-D'Amours, 2014). According to my informants' updates in 2013 and 2014, life at the clinic after the fence was built was unexpectedly calm. With patient numbers decreasing, no patient was turned away, and concerns about how much aid to give to which patients were gradually replaced by growing attention to advocacy measures on behalf of the thousands of asylum seekers who remained in detention facilities or who were still barred from access to government-sponsored healthcare (with little success on both fronts as of June 2016).

The dramatic rise in patient numbers during my tenure, then, proved temporary. But like many other humanitarian "emergencies," this sudden and unexpected rise in individuals needing treatment helped bring to light a series of interwoven, coexistent dilemmas that numerous aid organizations face in some way on a regular basis: should they treat as many patients as they can, or withdraw periodically in order to pressure states to act? Should they seek to expand their ranks and strive for greater efficiency through bureaucratization, or should they strive to maintain the scrappy, on-the-brink-of-collapse humanitarian image that will more easily preserve a semblance of humanitarian neutrality, compassion, and benevolence? (Calhoun, 2010; Redfield, 2013; Ticktin, 2011). Should they be held to account as organizations wielding a considerable power over lives and deaths, or should they still be considered underdogs fighting alongside their beneficiaries? (Fassin, 2007). Such dilemmas arise in countless aid settings in

diverse ways, and the historical circumstances at AHE provide a telling example of how and aid organization might grapple with several of these dilemmas at once.

A final question that remains to be addressed here concerns the degree to which psychosocial aid is representative of aid policymaking at large, and in what way, for that matter, the 2007 IASC guidelines are themselves a policy document. As I have acknowledged, it is possible to view the guidelines as less a serious effort at aid governance than a bland declaration of fealty to the popular buzzwords of the day – aid rationalization and sustainability. I am not overly inclined to the latter view, primarily in light of the considerable anxiety that the parachuting archetype appears to have aroused in the field. The guidelines are no lackadaisical white paper: the painstakingly broad ways in which both holism and sustainability mandates are articulated, as well as the broader debates about the ethics of aid delivery which they invoke, suggest that this was the beginning of a genuine but fragmented effort to reform the field. Is it likely to be taken seriously by frontline aid workers? Future research will tell.

REMAINING QUESTIONS AND FUTURE RESEARCH

The interplay between order and disorder that I have described leaves several important questions unaddressed that merit future research. First, if it is indeed possible for aid actors to conduct persuasive performances of rationality whilst acting very differently behind the scenes, then what is to prevent entire aid interventions from becoming completely decoupled, or habitually collapsing? How do the deceptions that persist in aid bureaucracies and in other organizations (e.g., the military, Wong & Gerras, 2015), in other words, not undermine these organizational cultures altogether?

Rottenburg insists that the “ritualized” reports that aid workers produce are not simply “Potemkin village facades” or “false messages,” but rather, “condensed ones” (p. 70). But how

does he know this is the case? What is included and what is omitted from such “condensed” messages? He insists, moreover, that loose coupling is not merely a reflection of corruption, but of the need to make aid projects succeed for the sake of recipients. However, how are we to tease apart instances of self-interest from ones of working for the common good, if under this framework they begin to look exceedingly alike?

One difficulty with the loose coupling theory, I suggest, is that it can collapse together actions that are in reality quite different in meaning, intent, and impact. For example, in chapter 5, the development consultant who interpreted the donors’ behavior in Eilar noted that perhaps they privately believed that the intervention was useless, but refrained from telling their supervisors because they knew that the latter wanted to stay in the region. Or perhaps they refrained because they knew they one failed intervention should not doom a long-term investment in Palestine. Or perhaps, yet again, they did not consider this failure at all, but simply business as usual in this republic of NGOs (Schuller, 2013). Yet these options obscure numerous, and even conflicting, possibilities at play: staying in a region that is considered “hot,” for example, could be done for reasons of organizational survival. But it could also be done out of a more genuine concern to not abandon Palestinians despite the interminability of their misery. And if donors did not consider this intervention a failure at all, then perhaps what was happening was not a deceptive maneuver, after all, but rather a redefinition of efficacy. Yet the loose coupling theory does not seem to permit such nuances, and collapses them instead all into the same broad phenomenon.

Thus, further research is needed to explore the relationship between order and disorder, and between governance and discretion, in humanitarian assistance. If we acknowledge that logframes are tweakable, then we must be careful not to assume in a facile that they are

indefinitely tweakable. In his study of IMF auditing, for example, Harper (2000) argued that IMF representatives took for granted the fact that the numbers they received from locals were unusable in their raw form and required some smoothing over by the right IMF representatives in order to make them official. In Harper's account, this smoothing over goes without a hitch: the foreigners do not appear upset or surprised at the dismal and chaotic conditions of the country's accounting, and cheerfully produce a polished tract at the end, nonetheless. Harper likewise notes no disagreements between the foreigners and the locals regarding how the numbers should be reconstructed to produce the final product.

Yet I would have precisely liked to see what would have happened if the auditors *had* found local numbers surprising or bothersome, or if the two parties had disagreed on the final product. What if, as Morten Jerven (2013) notes, the local economy had been difficult to tabulate numerically due to the habitual understaffing of statistical offices, or due to the fact that partly informal or barter-based economies are notoriously difficult to quantify? Explorations of such complex encounters, I suggest, would be welcome.

Power (1997) makes the compelling claim that audits often little more than the fact that something has been audited. While the circularity and recursiveness of this statement are surely intentional, we should be careful, I suggest, not to presume that audits reveal nothing about their objects, or that they reveal everything, but to rather explore the productive tensions between what they reveal and what they do not reveal, and between their symbolic and technical/informative aspects. One profitable direction such research could take, for example, would be to explore how humanitarian monitoring and evaluation (M&E), a burgeoning professional field in its own right, is carried out on a daily basis (Fernando, 2012). It is easy to imagine M&E consultants, who make a living evaluating aid efficacy, becoming irritated or

bursting into laughter upon reading Rottenburg's (2009) and Power's (1997) suggestions that evaluations are often little more than a ritual conducted for its own sake. It is important, I argue, to examine how their evaluations actually get taken up by their superiors, how they are used to reform aid NGOs that fall short of expectations, or how these evaluations get converted into policy - if at all.

Another topic worthy of study concerns institutional memory in aid organizations. As Rottenburg (2009) notes, the business of loose coupling in the name of project survival often requires substituting ceremonial facades for "truthful" reporting, which can result in "structural myopia and institutional amnesia" (p. 71). In other words, much of what really happens in daily practice gets forgotten or lost when aid workers leave – a reality to which my informants, including Milena, who spoke about reinventing the wheel and being hired twice for same job, ruefully attested. How is institutional memory and knowledge that is not captured in logframes and glossy donor reports, then, preserved over time? What informal techniques of codification, inscription and communication exist to compensate for aid organizations' forms of intentional and unintentional forgetting (Bowker & Star, 1999), and how are they used?

Two additional issues, I believe, are worth addressing in future research. First, my frontline informants often lamented the reality of short-term aid grants and named it the main obstacle to their work. But I was unable to find out why, exactly, short-term humanitarian grants of this nature were so prevalent. My searches through aid economics literatures yielded no analyses to explain how or why this pattern had materialized. New public management clearly favors both performance-based funding and quick measurement cycles (Kerr, 2005; Dar & Cooke, 2008). But the precise relationship between aid rationalization and aid funding, I argue, is still poorly understood and merits in-depth examination.

A final point concerns science and quantification. As I have briefly noted in this dissertation, aid and development organizations increasingly claim in their promotional and policy materials that their work is “evidence-based” or “research-based.” Seeing that few, if any, ever cited any actual studies to go with these claims, I attributed most of them to rhetorical flourishes seeking to benefit from an association with science, rather than actual scientific studies. Such references, indeed, used “evidence-based” loosely in ways that seemed synonymous with systematicity and rationality, thereby indicating broader rhetorical intent.

Such uses, indeed, recall Kregg Hetherington’s (2011) study of the use of the “information” in the context of development. Development actors in Paraguay, he argues, have promised to provide nothing less than “information” as their main deliverable: information about cadastral maps in rural Paraguay that would ostensibly help resolve important land disputes by giving everyone “information” about who owned what land. As Hetherington argues, such mentions of “information” were largely cynical efforts to mask land grabs from rural farmers, and had little to do with actual science or research, although development actors liked to insist that they did.

However, we can reasonably expect that soon, the use of the term “evidence-based” in conjunction with humanitarian interventions will no longer be primarily rhetorical, if it is now. Earlier, I referred to the small but burgeoning literature on the efficacy of humanitarian mental health interventions. These studies, I suggested, were still primarily the province of academics, not of humanitarian workers. Few of my practitioner informants could name any academic work or scientific studies pertaining to the efficacy of their interventions.

This is likely to change. Humanitarianism’s rationalization movement has boldly promised to reform aid with a global evidence base that will show, one and for all, which

interventions “truly work” (IASC, 2007; Mollica et al., 2004). Recalling Anica Kos’ (2008) critique of psychosocial evaluation in chapter 5, and specifically, her contention that important mental phenomena are difficult to measure and to render in quantitative form, it is important to ask which of the mental health interventions that are common today will survive such a revolution, and which will instead have to live on in semi-secret, loosely coupled form.

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