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“THE LEAST SEXUALLY CONFIDENT WOMEN IN THE WORLD”:
INTERNATIONAL NGOS AND THE RACIALIZED POLITICS OF OBSTETRIC FISTULA

by

Googie Karrass

A master's thesis submitted to the Graduate Faculty in Women's in Gender Studies in partial fulfillment of the requirements for the degree of a Master of Arts, The City University of New

York

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This manuscript has been read and accepted for the Graduate Faculty in Women’s and Gender Studies in satisfaction of the thesis requirement for the degree of Master of Arts.

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ABSTRACT

“The Least Sexually Confident Women in the World”:

International NGOs and the Racialized Politics of Obstetric Fistula

by

Googie Karrass

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In 2008, Christian author Shannon Ethridge pledged to donate a portion of the sales of her book *The Sexually Confident Wife* to the medial charity Mercy Ships International. Donations supported the provision of obstetric fistula repair surgeries for West African women who she dubbed “the least sexually confident women in the world.” This thesis asks what conditions occasioned Ethridge’s problematic statement and in so doing engages in a larger examination of evangelical NGO Mercy Ships, its history and contemporary practice, and the racialized, gendered and sexualized politics of fistula repair in international relief and development. First presenting histories related to the development of the international NGO, Christian medical missions to Africa and colonial and imperialist discourses surrounding the “protection” of colonized women, this analysis then turns to widespread donor and media portrayals of obstetric fistula. Staked in racist stereotyping and cultural pathologization, the typical narrative surrounding fistula, as this analysis shows, offers a site of convergence for the agendas of groups one would expect to be on opposite sides of a reproductive health issue, “progressive” feminists and religious conservatives. In this sense, obstetric fistula as a *cause du jour* reiterates long-standing racialized logics underwriting how colonial and humanitarian discourses have selectively become concerned with the plight of “Other” women for strategic means. In our contemporary context, this thesis argues, obstetric fistula as a cause can be read as a diversionary tactic and moral cover for the effects of neoliberal economic policy in the global south, a site of essential revenue generation for international NGOs and, finally, a sleight of hand that distracts from the unacknowledged conditions of patriarchy at “home.”

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INTRODUCTION

Shannon Ethridge and the “Least Sexually Confident Women in the World”

In 2008, evangelical author Shannon Ethridge posted a special promotion on the website for her newly released book, *The Sexually Confident Wife*. For every copy sold between September 15 and October 31st she pledged to donate one dollar to the charity Mercy Ships International to help expand their fistula repair program for women suffering from this “heartbreaking” obstetric injury. She dubbed these women “the least sexually confident women in the world” (Ethridge 2008). While she does not say so explicitly the “women” to which she refers are, as the optics of this page of the accompanying video make clear, impoverished African women. The embedded video, a still from which was pictured on the page, was produced by Mercy Ships International and posted on Ethridge’s channel, and features exclusively African women, lying in hospital beds, sitting outside run-down structures, and grinding herbs. It identifies “African women” as the main sufferers of obstetric fistula. Beneath this video the text reads, “If you’re as moved as we were when we first learned of this heartbreaking issue, you’ll be delighted to know that you CAN make a difference in these women’s lives!”(Ethridge 2008).

The title of this page, “The Least Sexually Confident Women in the World,” also appeared on the main menu of her homepage and, while the promotion ended in 2008, it remained on her homepage until at least 2013. Between “Special & Coupons” and “Speaking Request” Ethridge invited you to click to “Learn About The Least Sexually Confident Women in the World And How You Can Help.” This page stated that she had raised \$4, 658 in donations and provided information on the Mercy Ships International: “there’s still more YOU can do...”. The webpage for *The Sexually Confident Wife* has since been deleted and her current website

bears no trace of her statement regarding fistula sufferers. All records were recovered from the Wayback Machine and Ethridge's Youtube channel where the video still exists under the same title.¹

Shannon Ethridge's problematic assessment of women with obstetric fistula is best viewed in the context of her work on female sexuality. Self-described author, "life coach" and "advocate for healthy sexuality" Ethridge belongs to a group of evangelical writers who write on sex. Her work demonstrates Dagmar Herzog's statement that the religious American right is "above all a sexual movement" (Ethridge 2019; Herzog 2008, 159). This statement refers not only to the Christian right's extensive political organizing around sexual issues, like their fight for abstinence only education and against abortion, but also to the fact that evangelicals talk extensively about sex amongst themselves, conversations characterized both by moral determinations on good Christian sexuality and peppered by titillating sexual tales. As Herzog examines, the early 2000s saw the proliferation of books on sex from evangelical authors, notably the best-selling *Every Man's Battle* published in 2000. Directed at men struggling to "remain strong in the face of temptation" this book is filled with both salacious sexual anecdotes and scripture. Ethridge's *Every Woman's Battle*, published in 2008, framed as a sort of pro-woman intervention, was directed to Christian women who, like men, might be struggling with "sexual integrity." Women too, Ethridge argues, act out sexually, have premarital sex or emotional and sexual affairs, issues she diagnoses as stemming from low self-esteem and even sexual abuse. She draws from her own "promiscuous" past and her experiences as a mortician where she allegedly came face-to-face with the dangers of sexual immorality when embalming

¹ Records can be found on the Wayback machine (search: sexuallyconfidentwife.com) and Shannon Ethridge's Youtube channel, (<https://www.youtube.com/watch?v=jBeSXzIUslI&t=69s>).

“young people who had died from AIDS or committed suicide as a result of an HIV positive diagnosis” (Ethridge 2019). Her rhetorical and homophobia-inflected invocation of the moral and mortal endangerment posed by promiscuity emphasizes the difference between healthy sex (marital, heterosexual, non-fantasizing) and unhealthy sex, meaning anything else.

While *Every Woman's Battle* was directed at wayward women finding their way back to God, *The Sexually Confident Wife*, also published in 2008, was for “women who have shut down sexually.” Speaking in the language of sexual empowerment, colored by an almost feminist seemingly treatment of female pleasure and sex positivity, she writes, “every woman deserves to enjoy great sex with her husband, without inhibition or shame. But many wives live with the burden of self-doubt or feel mystified about *what men really want in bed*” (Ethridge 2019b). While at first glance Ethridge's own views towards gender, feminism, and the place of women are obscured by her candid and pro-pleasure stance, further inspection reveals the patriarchal, heteronormative belief underwriting her claims. While, via *Mercy Ships*' presentation, she recoils from the alleged oppression of women with fistula by what she implies are the barbaric patriarchal systems under which they live, her version of female sexual pleasure is critically constrained to heterosexual marriage and framed in some sense as a duty to one's husband and even to God. Despite her modern self-proclaimed frankness her views are nothing new. For example, when asked about how young Christian women could maintain “sexual and emotional integrity” she writes, “men may want to fool around with any woman who'll let them, but they want to marry the ones with self-control. Although it's a pathetic analogy in light of our human value, there's a lot of validity to what our moms told us: A man isn't motivated to buy the cow if you give him the milk for free” (Ethridge 2013). Number 18 of her “hot sex tips” for the sexually confident wife is “Turn up the Heat with Your Crock Pot,” suggesting that wives cook their

dutifully prepared nightly meal with a hands-off cooking appliance: “Make one evening a week ‘Crock Pot/InstaPot Night’ so that you can simmer together for a little while in the bedroom before joining everyone else in the dining room” (Bradshaw 2018).

With this context in mind, this thesis takes up Shannon Ethridge’s 2008 statement that African fistula sufferers are the least sexually confident women in the world as its starting point. It asks what conditions occasioned this statement and in so doing engages in a larger examination of the evangelical charity Mercy Ships International, its history and contemporary practice, and the racialized, gendered and sexualized politics of fistula repair in international relief and development broadly. While Ethridge’s husband Greg, tax records reveal, briefly served as CFO of Mercy Ships during the period of her book promotion, connections between Ethridge and Mercy Ships run deeper as both belong to American evangelical subculture. And, although Mercy Ships did not take up Ethridge’s troubling claim directly, its rhetoric on obstetric fistula is equally problematic and racialized. However, as this thesis explores, Mercy Ships’ presentation of fistula is representative of Western media and donor portrayals generally, no more problematic than the rhetoric of other organizations across the sector of international relief and development including those considered progressive.

Of further critical interest to this investigation is the fact that from 2005 to 2011, the period within which Ethridge made her statement, Mercy Ships International briefly, and curiously, partnered with left-leaning, pro-choice organization, EngenderHealth as part of a federal “reproductive health” funding package from USAID. Not unlike the way in which fistula sufferers are invoked by Ethridge to bolster her claims to a certain type of Christian female sexual empowerment, Mercy Ships’ fistula repair program, as I will show, bolstered their legitimacy as an organization, allowing them access to new streams of revenue. However, I will

also argue that viewing this partnership solely through the lens of cooptation does not adequately account for the ways in which obstetric fistula as a cause reflects a long history in which issues related to gender, when staked in the cultural pathologization of racialized “Others,” have presented sites of genuine convergence between Western progressive feminists and reactionary, social conservatives.

This thesis is divided into two parts. The first is focused on Mercy Ships International, with a specific emphasis on its style of fundraising, financial structure, and particular version of Christian culture. It explores how Mercy Ships fits into the larger world of international NGOs and particularly of evangelical relief and development organizations that have a somewhat unique history that will also be detailed here. I will elaborate three historical backstories critical to understanding Mercy Ships as an entity and its particular engagement with obstetric fistula: the rise of the phenomenon of modern international relief and development Non-Governmental Organizations (INGO), and evangelical organizations in particular; the history of colonial medical missions in Africa; and the sexualized, racialized and gendered logics that have long undergirded, and still undergird, the project of “saving” women endemic to the colonial and, arguably, humanitarian project in Africa and elsewhere.

The second part focuses on obstetric fistula as a *cause du jour* in women’s health. I will present Mercy Ships’ fistula repair program and partnership with Bush administration-run USAID and fellow NGO EngenderHealth in the context of the rise of “women’s health” agendas in international aid. While concerned with the potential cooptation of these agendas by forces hostile to a broader feminist agenda, this analysis turns on the fact that Mercy Ships’ portrayal of obstetric fistula and utilization of fistula repair surgery, although fitting with their evangelical character, is in most ways identical to that of mainstream relief and development organizations

across the religious and ideological spectrum. Engaging in a discursive analysis of the typical stylized narratives, I examine the ways in which obstetric fistula is portrayed by these sources in racially coded language as a cultural issue, the emphasis placed on the supposed cultural “rejection” of women with fistula – rather than on the lack of obstetric infrastructure and access to emergency c-section that is actually at fault for obstetric fistula in Sub-Saharan Africa. In this sense, I make the case that obstetric fistula as a cause draws on the racist choreography of the colonial medical mission through which Africa was rendered a site of pathology and in which illness was attributed to “cultural” factors. These narratives, I will show, also directly reiterate long-standing racialized, sexualized and gendered logics underwriting how Western discourses, colonial and humanitarian, selectively became concerned with the plight of colonized women for strategic means.

In our contemporary context, this utilization of “women’s health” is related to the neoliberal economic and ideological conditions under which international relief and development NGOs operate. As critics have argued, in this landscape “cultural” issues related to gender often function as a cover for the destructive effects of neoliberal agendas in the global south and Africa in particular.² I argue it also reflects how long-standing sentiments related to saving colonized women have become monetized in the marketplace of international relief and development through the solicitation of donations. The hypocrisy of Mercy Ship’s, like Ethridge’s, utilization of women’s empowerment rhetoric and its engagement with fistula repair can be read as a way in

² Elaborated further on p. 59. See chapter five of Eisenstein’s *Feminism Seduced* (2009) for a presentation of the argument that “women’s issues” have replaced state-led development and function as “sleight of hand” for neoliberal policies. Such dynamics are at work in micro-credit programs for example, which target women specifically (see Feiner and Barker 2009; Ananya 2007; Bello 2006) and the manner in which programs supporting the flowering “civil society” have replaced civil development (see Wickramasinghe 2005). Further accounts related to NGOs specifically include Fernández-Kelly (2007) and Alvarez (1999), which focuses on Latin America.

which it was able to participate in the thriving market of “women’s health” in global health funding circles. However, their participation points to broader issues in the field of women’s health as carried out by Western INGOs, conservative and progressive alike. In some cases, like the case of the stylized narratives of obstetric fistula, discourse that lays claim to the “defense of women” must be viewed in a matrix of racism, sexism, colonialism, imperialism, and in the contemporary landscape, neoliberal policies directed at the developing world that have been to the detriment of women in particular.

Portrait of Mercy Ships International

Mercy Ships International is an American Christian charity headquartered in Garden Valley, Texas. Founded in 1978 by members of an evangelical ministry Don Stephens and wife Deyon Stephens, Mercy Ships’ mission, per its website, is to “follow the 2000-year-old model of Jesus, bringing hope and healing to the forgotten poor.” It currently operates the largest privately owned hospital ship in the world, the *Africa Mercy*, and its central activity is the provision of medical care, primarily surgeries. Doctors perform surgeries in operating galleys aboard a converted Danish rail ferry divided into five wards with 80 patient beds and berths for an average of 450 crewmembers. Aside from management, the staff and crew are predominantly unpaid, self-funded volunteers who stay on board for a minimum of two weeks and often for months to years at a time. Oftentimes, entire families move onboard, children attend The Academy, the ship school that goes from kindergarten to 12th grade.

Mercy Ships has served over 65 countries but for the past few decades, and with the deployment of the *Africa Mercy* in 2007, it has worked almost exclusively in the West African coast, where it docks in port cities for about a year at a time. Its most recently served areas were

Doula, Cameroon from August 2017 to June 2018 and Conakry, Guinea from August 2018 to June 2019. While Mercy Ships engages in “capacity building” programs ashore, “working with local medical communities to train professionals, providing medical tools and resources, establishing outpatient programs and participating in agricultural programs,” at least per their website, the majority of their work consists of on board medical screenings and surgeries. According to their website in 2017 Mercy Ships performed 2,792 “life-changing” surgeries, 19,309 dental procedures, over 35,488 potential patients were screened for surgery, and 1,820 local African healthcare professionals were trained. The most common procedures performed are those treating cleft palate, maxillo-facial and tumor, eye, scar tissue and, most centrally to this discussion, vesico-vaginal fistula (Lange 2016).

While well below the revenue of the world’s largest US-based International Non-Governmental Organizations (INGOS)—World Vision for example had revenue of over one billion in 2017—Mercy Ships’ 2017 909 tax form reports revenue of \$71,253,635, \$300 million in assets, and \$900,500 paid to directors, trustees and key employees. Mercy Ships’ president Don Stephens had a reported salary of \$293,187 in the 2017 fiscal year, in the normal for top NGO management.³ It became a 501(c)(3) organization in 2008 and is funded by private individuals, “related organizations” (terminology that for religious non-profits typically refers to church associated organizations and funding apparatuses), and corporate sponsors, like Johnson & Johnson, Cisco and Microsoft. In 2017 contributions totaled \$69,701,595, none of which came from “government grants,” with \$1,778,588 in “program service revenue” generated from crew-member fees which are roughly, at present in 2019, \$700 dollars a month for adults from developed nations (Mercy Ships 2019). It is notable and rather unique to Mercy Ships that even

³ Information found at CharityNavigator.com. For comparison, the CEO of World Vision had an official salary of \$456,503 and the CEO of CARE earned \$395,466 in FY2017.

high-ranking staff like the head physician are self-funded and do not receive a salary. This pay-to-work operation scheme, which capitalizes on the earnestness of its volunteers, in addition to private funding, allows Mercy Ships to maintain independence from larger funding structures, from the US government, the UN, and others (Lange 2016, 34).

Mercy Ships fundraises across many media platforms, engaging in extensive direct mailing, internet, and television campaigns, as well as the occasional TV special including a glowing 60 Minutes profile in 2013. Its fundraising approach is characterized by before and after photos of visibly disfigured individuals, uniformly Africans, with nationality very rarely identified. Their direct mail campaigns feature a warnings like “disturbing images within” and often include a mock-up of a dollar-matching check with the message “Your gift multiplies in impact to deliver life-changing surgeries to the forgotten poor” (Mercy Ships 2019). The fact that nearly all of Mercy Ships’ revenue is generated from private donations is reflected by the almost four million dollars spent on advertizing and promotion with a separate 1.8 million on “professional fundraising services” in 2017, 16% of total expenditure. While it is relatively well rated by charity watch groups and accredited by the Better Business Bureau—their program spending made up an acceptable but not impressive 77.5% of their expenses in 2017—this fundraising figure stands out. It is nearly double that spent by organizations like World Vision, Save the Children and the American Red Cross, all of which have extensive fundraising campaigns.⁴

As is the case with many similar organizations, placing Mercy Ships within a taxonomy of international faith-based non-governmental organizations is not straightforward (Berger 2003;

⁴ Information retrieved from Charitynavigator.com, which provides information on charities gleaned from their public 909 tax forms. It reports the fundraising budget as the percentage of overall expenses. World Vision: 9.3% (FY 2017); Save the Children: 7.3% (FY 2017); American Red Cross: 6.4% (FY 2018).

McCleary and Barro 2008; Thaut 2009).⁵ While it does not directly engage in evangelizing and offers care to those from all faiths, it is a highly Christian organization characterized by American evangelicalism. This is apparent in its mission, to “follow the model of Jesus,” core values, the first of which is to “love God,” and reflected by the ship’s culture that centers on prayer and ministry and crew policies that include the prohibition of fraternization of unmarried crew members of different genders past a certain hour. Accredited by the Evangelical Council for Financial Oversight, its founder and president Don Stephens, along with its volunteer crew, participants and employees have a strong connection to the evangelical community, both in the US and internationally, in Australia and the UK in particular. At the same time it engages in broadly non-denominational Christian language and, in some ways, its discourse is indistinguishable from that of INGOs from across the spectrum. Its fundraising appeal, reliant on the portrayal of suffering “others,” is practiced broadly across the sector and, of import to this discussion, its “women’s health” program reflects industry-wide norms.

In order to understand Mercy Ships’ mission, approach, work, fundraising strategy, financial structure and its fistula repair program, it is necessary to unpack three histories referenced in the introduction related to the modern NGO, Christian medical missions and the call to “save” indigenous women in colonial possessions. The next section details these social and geopolitical contexts and sets up an analysis of Mercy Ships as an organization and its particular engagement with fistula repair program in the early 2000s.

⁵ My approach to this classification relies heavily on the work of Robert Barro and Rachel McCleary (2008), and Leah Thaut (2009) who offer critical frameworks, definitions and taxonomies for addressing the degree of secularity or religiousness in internationally operating humanitarian organizations. While McCleary and Barro make the point to use the term Private Voluntary Organization (PVO) rather than Non-Governmental Organization (NGO), for reasons related to their data collection and classifications determined by USAID’s registry, I will use the term International NGO as it is more widely used and easily recognizable.

HISTORICAL BACKSTORIES

The Rise of the International NGO

Pre-War to the 1970s: Profit and Professionalization in the Decade(s) of Development

The rise of the modern US-Based international NGO, secular and evangelical alike, can be divided roughly into two eras. Following World War II through the 1960s, humanitarian organizations professionalized and homogenized, developing complex fundraising strategies and reaching into new international geographic eras in the context of the Cold War. Evangelical organizations, examined here through the paradigmatic and largest such organization World Vision, remained relatively immune to the trends affecting the rest of the sector during this period. With the exception of shared fundraising appeals, evangelical organizations reflect a distinct history intertwined with America's evangelical subculture. The second era, beginning roughly in the mid-1970s and marked here by the founding of Mercy Ships in 1978, constitutes a NGO boom characterized by the ascent of neoliberalism as an economic model and ideology. Despite their rather separate history, during this period of explosive growth, evangelical organizations like Mercy Ships were able to participate in the booming market in newly profitable ways.

The largest and most well-known international NGOs operating today began as relief and rescue organizations formed in response to humanitarian crises created by the great world wars (Stoddard 2003, 26). Save the Children, for example, was founded in 1919 by British sisters Eglantyne Jebb and Dorothy Buxton to address the starvation of German children resulting from the Allied blockade and CARE, originally Cooperative for American Remittances to Europe, was

formed in 1945 as a temporary operation for sending aid packages. Differences between religious and secular organizations were minimal, the Catholic Relief Services, for example, was founded under similar circumstances by Catholic Bishops in 1943 to meet the needs of European refugees, and the colonial service mission served as a model for organizations of all types (Riddell 2007, 25). Under the influence of several intersecting geopolitical, economic and social dynamics, however, these originally spontaneous emergency efforts transformed into modern relief and development agencies following the Second World War (Rosenberg 2003, 249; Rozario 2003). By the mid-1970s, many organizations had revenues in the multi-millions and were established geopolitical actors.

The advent of modern foreign aid and the geopolitical context of the Cold War were critical to this development. As the field of international development matured following World War II, and with the growing prominence of human rights frameworks and international bodies like the UN, private humanitarian organizations that had emerged in response to war crises became vehicles for the long term objectives and agendas of newly established international organizations (Riddell 2007, 25; Rosenberg 2003, 251). While the idea of governmental aid to foreign states can be traced back to British and French colonial development acts from the 1930s and 1940s, foreign aid became institutionalized as part of the US policy agenda in new ways in the context of the Cold War. By the mid-1950s foreign aid was a pillar of the US anti-communist strategy. Official Development Aid (ODA) budgets grew and agencies, predecessors of United States Agency for International Development (USAID), founded in 1961, were established to manage the distribution of funds (Rosenberg 2003). During this period, the US public became especially amenable, compared to European counterparts, to the idea that the government should engage in foreign humanitarian aid as a moral and political project and began to understand that

foreign aid could “build markets and secure strategic gains for the nation, as well as express humanitarian concerns” (Rosenberg 2003, 250–51). This ushered in the so-called decade of development, the 1960s, during which international development aid, from Western governments and the US especially, grew steadily, efforts directed to parts of the world where Soviet influence loomed, namely East Asia (Vietnam, China and Korea), Eastern Europe and newly independent African states (Lindenberg and Bryant 2001, 6). Private humanitarian organizations thrived, their programs shifting toward the emerging field of relief and development, as they received US federal funds, support from newly formed UN agencies and individual contributions from a public increasingly willing to make financial contributions to international humanitarian causes (Stoddard 2003, 27).

The changing agendas and newfound financial viability of these organizations was supported by a process of professionalization that extended to their approach to aid, self-presentation and management style. Agencies interacted with emerging academic fields related to international relations and economic development and many developed long-term projects that far exceeded the original scope of crisis response (Rozario 2003). In this context, while organizations still engaged in crisis and emergency relief—such efforts were often the centerpiece of their fundraising appeals—they adopted a more rationalist mode of humanitarian aid. Influenced by turn-of-the-century ideas related to scientific philanthropy, rationalist approaches had gained prominence with the emergence of large philanthropic organizations, like the Rockefeller and Carnegie Foundations, and professional fields like public health and social work. Unlike past models of charitable giving that focused on individual person-to-person aid scientific giving focused on systemic, long-term solutions and the root causes of social problems. This approach, would, for example, look to cure disease rather than simply build a hospital or, in

the era of international development, invest in economic development rather than simply provide food packages (Sealander 2003). In this context, the concept of individual charity, one concerned with providing alms to the poor practiced historically by churches, was at least in part abandoned by emerging NGOs in favor of methods oriented by long-term impact that importantly, in a industry looking to demonstrate its viability to donors, allowed for estimations of efficiency. Today, for example, CARE delivers not supplies but “lasting change”: “Instead of delivering powdered milk in boxes, we teach women to raise their own cows. Instead of sending notebooks and pencils, we train teachers, build schools and show parents how educating all of their children is the best investment they can make for their family’s health, prosperity and happiness” (“CARE Package: Deliver Lasting Change” 2019).

This more systematic understanding of humanitarian aid was co-constitutive with a process of bureaucratization and professionalization. Throughout the 1950s, organizations were increasingly managed like for-profit businesses rather than spontaneous crisis response efforts, streamlining their managerial approaches and financial structures. While their goals were of course different from for-profit businesses—revenue was largely directed at their expanding charitable programming rather than the enrichment of shareholders—increasing income also supported organizational growth, the emergence of complex professional structures, overhead costs and the salaries of the professional staff needed to operate these programs (Riddell 2007).⁶ Throughout the 1950s and 1960s many relief and development organizations adopted corporate

⁶ There is however, as Roger Riddell examines closely and as will be explored here in the next section, a difference between money spent on programming and money that goes directly to beneficiaries. Determining the level of self-interest in these fundraising efforts is not straightforward as on one hand, efficacy of their projects aside, good faith charitable work is likely the central motivator of those working at NGOs. On the other hand these organizations are now part of a multi-billion dollar industry upon which many people rely for employment, those in top positions earning salaries that while less than that of the average CEO are substantial.

structures and verbiage, hired from the private sector, and, perhaps most importantly, developed professional fundraising campaigns (Rozario 2003; Rosenberg 2003, 251).

The emergence of publicity departments and utilization of complex fundraising strategies that, for the first time, were able to draw sizable donations from individual donors was critical to the ascendancy of the modern NGO. Facilitated by the maturation of mass media and the advent of the fields of publicity and advertising, beginning in the early 20th century fundraising, understood as a behavioral science, became a central part of the operation and financial viability of these organizations (McCarthy 1989, 54–55). Individual donors could now be reached by mail, radio and television fundraising campaigns and organizations employed specifically tailored strategies depending on their audience and context (Rozario 2003). Some made rational appeals, emphasizing the efficiency of each dollar donated or the structural impact of their projects, while others made a more emotional appeal characterized by typically maudlin narratives of individual suffering. In this sense, targeted fundraising campaigns drew on long-standing humanitarian logics and traditions that associated depictions of pain with sympathy: “The modern pornography of pain” as Karen Halttunen notes, was an “integral aspect of the humanitarian sensibility” that had taken shape in the 18th and early 19th centuries (Halttunen 1995, 304).

However, these sentiments became monetized in new ways in the postwar American economy via the mass media and its ability to solicit individual contributions from a wide audience. The viability and operation of these organizations, relatively new entities, relied in part on their ability to convince the individual person to donate, something the American public

was increasingly able and willing to do during this period (Rozario 2003, Magat 1989).⁷ While many forms of media demonstrated and profited from images of suffering and tragedy, with the activation of this individual donor base the use of such imagery and narratives—printed and distributed through magazines as pioneered by late 19th century medical missions and the Red Cross, as direct mail campaigns, and later portrayed on television—reached new heights of profitability for humanitarian organizations during the second half of the 20th century. This fundraising style, which continues to dominate today, is characterized by often-graphic photography, tragic narratives and the call to “donate now.” The “sponsor a child” model, in which your donation is said to support the life of one specific child, first developed by Save the Children during World War I and later taken up by many, has been especially prolific and effective (Rozario 2003, 427). In this respect, and essentially here, while the activities and frameworks of internal humanitarian organization evolved to address what they considered the root causes of poverty and their rhetoric secularized in pursuit of donations from both state-sources and religious and secular donors, many continued to rely on the portrayal of individual suffering in order to draw donations.

American Evangelical Humanitarianism and the Parachurch Mission

These developments can be put in conversation with the history of evangelical relief and development agencies to which Mercy Ships, in many ways, belongs. Although evangelical organizations mirrored trends in American humanitarianism generally in some respects— most notably their embrace of the “spreading of US values” and adoption of similar fundraising

⁷ Previously the domain of the wealthy, the mid-1960s saw a sharp rise of individual household charitable giving to causes of all types, which supported the growth of the non-profit sector (Magat 1989, 5–6).

strategies—evangelical humanitarian groups acting internationally and at home resisted the professionalization and homogenization that affected the rest of the non-profit sector. This dynamic is best represented by World Vision the sole organization of the super NGOs operating today with roots in American evangelicalism. Its history allows us a window into American evangelical subculture and its particular style of humanitarianism that Mercy Ships inherited.

While founded in the same period as super NGOs like Save the Children and CARE, World Vision was not a response to a World War II caused crisis. Rather, it was founded by an evangelical pastor, Rev. Bob Pierce, in 1950 in response to his experiences in China with the evangelizing mission organization Youth for Christ. The history of the evangelical parachurch mission, of which Youth for Christ was one, is critical to understanding Mercy Ships' and its particular character as it diverges from that of mainstream NGOs. Youth missions, like Youth for Christ and Youth for a Mission, the organization with which Don Stephens working when he founded Mercy Ships, entered American evangelical life in the 1940s as a new generation of evangelicals sought to re-incorporate service and concern for the needs of the poor. This followed a period, from roughly 1900 to 1930, during which, according to George Marsden, in reaction against a prior liberal protestant "social gospel" phase, "all progressive social concern, whether political or private, became suspect among revivalistic evangelicals and was relegated to a very minor role" (Marsden 1980, 90). Rooted in a philosophy of "social-reconstruction" most Christian fundamentalists, a group united in the early 20th century by shared attacks on secularization, evolutionary theory and historical relativism, remained strongly committed to economic liberalism and vehemently rejected mainline protestant efforts for social justice and the welfare state which they feared "would weaken patriarchal dependencies" (Hofer 2003, 337).

Following World War II, however, a new generation of conservative Protestants calling themselves evangelicals, encouraged the re-entry of social concern to fundamentalist culture through the longstanding fundamentalist tradition of the parachurch organization.⁸ Parachurch organizations, which stand separately from any particular denomination, allowed protestant fundamentalists to engage in missionary work and address social concern apart from mainline Protestant organizations many of which were developing more complex understandings of systemic violence and structural inequity viewed suspiciously by evangelicals. Parachurch youth missions cleaved closely to a missionary model, centered evangelizing and operated under an individualistic view of charity in which aid was given to “deserving” individuals (Vanderpol 2010, 28).

Evangelical relief and development agencies, like World Vision and Mercy Ships, that grew out of these parachurch missions share fundamental characteristics that distinguish them from mainline protestant and secular international NGOs. Firstly, while many INGOs do not have a public-facing leader, preferring to present themselves professionally rather than through the personality of their CEO or founder, evangelical humanitarian organizations, like many American evangelical institutions, typically revolve around the vision and personality of a male leader and founder, like Mercy Ships’ Don Stephens (Thaut 2009). Financially, evangelical organizations were less likely than both secular and other religious organizations during the post-war period to receive federal funding in part because such money was treated with suspicion by organizations who looked to maintain independence from secular forces (Thaut 2009, 329;

⁸ Evangelicals looked to unite conservatives after what had been divisive years within fundamentalism. This return to social engagement was facilitated both by a movement of evangelical leaders who wanted to establish intellectual legitimacy, notably through the Fuller Seminary founded in 1947, and by the engagements with the poor facilitated by the increasing missionary activity (VanderPol 2010, 32–35).

McCleary and Barro 2008, 523–24).⁹ World Vision of the 1950s and 1960s, in the model of parachurch missions, relied mostly on an independent funding base through churches and individuals rather than the development aid that flowed freely during this period.

At the core of the differences between evangelical and mainstream relief and development organizations was the nature and approach to humanitarianism that endures today. In a sense, evangelical organizations like World Vision were impervious to much of the ideological shifts occurring across the rest of the development aid world and its research. While many mainstream religious organizations had partially secularized in order to appeal to a broader base of donors and gain access to government funding sources—toning down the overt religiosity of their language or distancing themselves from a particular denomination—this was not the case for evangelical organizations. Even evangelical international relief and development organizations that did not directly center conversion in their mission organizations had a distinctly spiritual, Christian character borne out in their work and discursive presentation. Their approach was, and continues to be, characterized by a sense of spontaneity, individual compassion, and a sincere belief in miracle and prayer. While other international humanitarian organizations that emerged after the world wars became interested in the root causes of poverty and adopted research-based solutions to humanitarian issues through the 1950s and 1960s, World Vision and others remained focused on individual compassion and person-to-person giving which had characterized Christian missionary work for centuries. World Vision, reflecting the views of most evangelical Americans, fundamentally believed that “meeting spiritual needs was

⁹ Scholars have observed a negative relationship between level of religiosity and share of government funding. As Berger writes, “To maintain organizational independence, most [religious] NGOs are privately funded, with the substantial portion of their financial resources coming from members in the form of donations, dues, or established tithing mechanisms within the religion itself” (Berger 2003, 28). For further discussion see Thaut (2009).

a prerequisite to effectively dealing with material needs” and therefore sought spiritual and material solutions to poverty (VanderPol 2010, 64). Conversion was considered an essential component of the project of curing poverty and remained central to World Vision’s efforts. As VanderPol notes, in the tradition of Christian fundamentalism and missionary work, “Pierce strongly believed that religious conversion brought tangible social, material and political benefits to individuals and even to entire societies” (62). This tradition, in stark contrast to the belief-system of the international agencies engaged in long-term projects aimed at economic development, believed the causes of poverty to be in part spiritual in nature. World Vision’s spiritual approach to charitable giving fit very specifically within the political and ideological particularity of Cold War era American evangelicalism, anchored in a belief in individualism and free market liberalism. Evangelicals engaged overseas saw themselves, more zealously than most other humanitarian groups, as engaged an ideological battle against communism, directing themselves at the hot spots of the Cold War, World Vision focused on China and Korea, evangelizing both Christianity and to capitalism (King 2012).

One area in which evangelical and mainstream INGOs have a shared history was the development of fundraising methods to solicit individual donations and the embrace of mass media. Gary VanderPol points out this strange tension between the “spontaneously spiritual and the rationally technological” at World Vision and in evangelicalism broadly (Vanderpol 2010, 82). He writes, “World Vision was strongly committed to a supernatural worldview in which God’s special providences ensured staff that they were doing God’s will, yet was equally beholden to Enlightenment modernity, whose gifts of technology, science, and organizational bureaucracy were God’s chosen instruments to succor the poor” (VanderPol 2010, 87). This

embrace of technology extended both to medicine, an inheritance of the Christian medical mission to which I will return, and to media.

The savvy utilization of mass media, television and radio in particular, played a large role in the growth and character of evangelical subculture in the United States in the 20th century. Well known for their AM radio programming and development of the unique phenomena of televangelism, Christian conservatism was also an early and enthusiastic adopter of direct mail fundraising, a method integral to evangelicalism's political activation. Richard Viguerie, the so-called "founding father of funding" of political conservatism, first utilized direct mail for Barry Goldwater's 1964 campaign but eventually, as an independent consultant, applied his techniques to a variety of conservative causes that included "humanitarian" work overseas.¹⁰ World Vision was very much part of this culture, utilizing direct mail and television ads early on, engaging in an overall strategy of "aggressive, organized appeals for funds on as large a scale as possible" (VanderPol 2010, 86). In other words, the conservative movement, of which World Vision was a part and into which Mercy Ships entered, was well-versed in the fundraising appeals that worked for their audience, the media apparatus of direct mail and television, and understood how these methods could generate revenue. By the early 1950s, World Vision founder Bob Pierce developed extensive direct mail campaigns and introduced the concept of child sponsorship, originally for Korean orphans which eventually became the backbone of World Vision's funding (King 2012, 928).

¹⁰ His involvement in one such effort, a "sponsor a child" model campaign for the Korean Cultural and Freedom Foundation fundraising for Asian Children's Relief fund, resulted with a charge by New York's general attorney for siphoning the majority of the funds in 1977. The charge alleged that the fund-raising literature produced by Viguerie for \$920,302 was "calculated to deceive the contributing public into believing that the greater portion of the money contributed would be expended for the specified program services" (Clairborne 1977).

While this fundraising approach was by no means particular to World Vision or evangelicalism, the portrayal of individual suffering corresponded to a evangelical's sincere belief in person-to-person aid (VanderPol 2010). Fundraising appeals that highlighted a call to action, asking the reader to help "just one" suffering child, were well suited to the individual charity model at the root of evangelical attitudes toward humanitarianism. World Vision's material had a particular character, relying even more heavily than others on a straightforward visceral portrayal of individual suffering through photographs, often emphasizing the distinction between middle class American lifestyle and conditions abroad. Aligned with its political conservatism it avoided any reference to Western complicity in the conditions of poverty, rather, writes VanderPol, "World Vision's call to Americans Evangelicals was simply to share all the good things—both spiritually and materially—with which they were blessed." (68). While the lack of sophisticated analysis is of course in no way specific to World Vision, the denial of western complicity in global conditions of poverty was especially pronounced in World Vision's early decades when compared to mainline protestant organizations many of which adopted more left-leaning Christian approaches to social justice. World Vision did go on in the 1950s to support long-term projects but their approach remained oriented by person-to-person giving rather an effort to address the root causes of poverty (King 2012, 75; VanderPol 2010, 67). In a sense, while World Vision and other organizations shared some overlapping objectives and fundraising strategies they were in different worlds (King 2012, 928).

While evangelicalism's unique approach to relief and development—mixing faith and prayer with media and medical technology, with an emphasis on the supremacy of Western values and capitalism—turned out to be fairly successful on the level of the individual donation, World Vision and other evangelical organizations remained relatively niche during this period,

lagging well behind other NGOs throughout the 1960s. However, this would change as the decade of development (1960-1970) came to a close and the forces of neoliberalization altered the NGO landscape. This would occasion World Vision's ascent from among the smallest INGOs to the largest NGO by revenue in the world in 2001 and the emergence of Mercy Ships in 1978.

1970s to Present: Neoliberalization and the NGO Boom

While the 1960s was the decade of development, the 1970s and 1980s saw a contraction of foreign aid. Successive economic declines had a profound effect on both the size of official development budgets and the ethos toward the dispersal of aid. International financial bodies like the IMF and World Bank became major regulators and thought-leaders in the field and encouraged the adoption of a neoliberal ideological approach to development as cuts in public spending in the North were felt across the globe. Despite these economic contractions and budgetary cuts, however, the late 1970s through 1990s saw a boom of international NGOs. The growth of the private international humanitarian relief and development sector was in fact facilitated in part by these economic conditions. Privately operated international development agencies fit nicely into the ascendant neoliberal worldview that viewed human welfare best served by the withdrawal of the state (Harvey 2005, 64). The World Bank in particular took the lead in persuading donors to adopt a neoliberal mindset aimed at reducing state activity: "As big interventionist government was believed to be a major cause of the economic woes of the industrialized world, it was a relatively short step to believe that these were also obstacles to the development of poor countries" (Riddell 2007, 34). As austerity measures were enforced through structural adjustment and state-led development was stymied, private organizations, seen as the

solution to development, were positioned to fill voids in civil space (Lindenberg and Bryant 2001, 9).¹¹ NGOs entered in the vacuum left by social and state services in the global South and served as alternative conduits to states for the distribution of aid (Lindenberg and Bryant 2001, 11).

This was particularly expressed in Sub-Saharan Africa, which became the major region of focus for international relief and development in the 1980s. The donor community turned especially wary of the “corruption” and socialism of newly independent African governments that emerged out of a second wave of independence movements in the 1980s. Sub-Saharan Africa also was also the subject of increasing global attention with a succession of high-profile reports focusing on the region’s struggles and a number of natural disasters that were covered extensively by “Western” media outlets (Riddell 2007, 36). Investments from the “West” that had formerly taken the form of development aid given directly to governments took the form quick-disbursing loans that went through the increasing number of NGOs (Bornstein 2005, 15; Eisenstein 2009; Wickramasinghe 2005, 467). Mirroring the period of colonization, private Christian humanitarian organizations based in the “West” filled the gaps in public welfare. Local church-affiliated NGOs were especially favored as aid recipients, many developing relief and aid wings in order to be eligible for USAID funding (Gifford 1994, 513, Hofer 2003, 383–84). Despite the proliferation of NGOs, the dismantling of state-sponsored development and public sector institutions like public education and healthcare had severe effects on the economies, political stability and social welfare of African states and markers of human welfare declined

¹¹ Structural adjustment packages are loan agreements that nations in the global south were required to accept under the conditions of the “debt crisis” of the 1980s. They stipulated particular conditionalities determined by international lending bodies, notably they deprived and governments of the tools to invest internally and engage in necessary state-led development. Instead, they prioritized the development of industries useful for export earnings (Eisenstein 138). For more on the functioning of SAPs see Klein (2007) and Chossudovsky (2003).

steadily across the continent throughout this period (Chossudovsky 2003, Eisenstein 2009, 142).¹²

In sum, throughout the 1970s and 1980s, despite economic downturns and overall cuts to official development aid budgets, INGOs thrived, receiving increasing state funding and a massive influx of private donations. Between 1970 and 1994 the number of internationally operating NGOs registered with USAID grew from 52 to 419 and their revenues increased 11.3 fold, from 614 million to 6.6839 billion, at a rate faster than both U.S. total giving and U.S. GDP (Lindenberg and Bryant 2001, 3). In 2003, according to Stoddard, INGOs received an estimated one-quarter of (northern) governmental humanitarian spending (Stoddard 2003, 25).

The massive growth in this sector, understandably, altered the structure and activity of these organizations and abetted the rise of a few dozen NGO giants, which continue to dominate today. Most of these organizations, Stoddard notes, shifted “from initial emergency aid deliveries to long-term, anti-poverty activities in the developing world” and in many cases, as examined here, occupying service areas that were once the domain of the state (25). Massive revenues were directed at increasingly complex and large-scale programming, supporting the organizational structures, staff, overhead costs and so on that came with their expanded program portfolios (Stoddard 2003, 25).¹³ Programming costs increased as organizations expanded geographically. As Lindenberg and Bryant describe, many agencies went from simply exporting services to developing complex domestic organizational structures, setting up overseas offices, designing

¹² For further discussion on the effects of structural adjustment packages on human welfare and women and children in particular see Afshar and Dennis (1992), Sparr (1994) and Moghadam et al. (2011).

¹³ NGO giants, which include CARE, Médecins Sans Frontières (MSF), Oxfam, Save the Children and World Vision, now operate as multinational umbrella-like federations made up of many local chapters. By 1999 their revenues were all between \$300 and \$600 million. In millions (USD) CARE: 525; MSF: 304; Oxfam: 504, Save the Children: 368; World Vision: 600 (Stoddard 2003, 25).

and delivering programs through their own registered organizations and hiring networks of local field staff (Lindenberg and Bryant 2001, 6–7). In this context, NGO revenue has been by and large directed at their charitable work. Programming makes up around 80% of most organizations' expenditure, numbers that they were, after a series of transparency crises, required to report.¹⁴ The remaining 20% goes to fundraising and administration.¹⁵

However, as Riddell notes, programming as a category almost always includes the costs associated with program administration and therefore the salaries of north-based and local staff in addition to transport and subsistence costs (Riddell 2007, 279). These costs are considerable. As Riddell observes, “except in the case of large projects, they are likely to amount to a significant share of total project costs, often in excess of 20 per cent” (279). Furthermore, as Riddell and many others examine, how effectively this money is spent, what amount actually reaches the intended beneficiaries, and how effective the programs themselves are is an open question. Addressing this subject is complex in part because, as Stoddard observes, NGOs navigate multiple tiers of accountability, at once charitable organizations and participants in an economy like any other where they must compete for market share. She writes, “Whereas an employee of a business venture has the relatively clear-cut goal of increasing profits, growth and market share, the typical NGO worker must juggle competing loyalties: the needs and interests of the beneficiary, the desires of the donor and the interest of the organisation to survive and

¹⁴ See Gibelman and Gelman (2004) for discussion of public scandals in the NGO world that proliferated in the 1990s and their effects.

¹⁵ Organizations are required to report the salaries of upper-management. For the world's largest NGOs CEO salary makes up around .05% of their expenses (Mercy Ships' president Don Stephen's salary is .5% of Mercy Ships' expenditure). Some of the CEO salaries reported for the 2017 fiscal year were: World Vision: \$456,503; Catholic Relief Services: \$417, 723, and CARE: 395,466. It's noteworthy that Franklin Graham's salary, CEO of Samaritan's Purse, a reported \$612,422, is significantly higher than that of the CEO of much larger organizations (CharityNavigator.com).

grow. These three sets of interests conflict with each other at least as often as they overlap” (34). Complications and competing interests aside, however, it is safe to say that throughout the 1970s and 1980s international relief and development NGOs gained access to revenue on a previously unseen scale.

This massive market growth, and the ideological and economic conditions that abetted it, were especially beneficial for evangelical organizations. Between the 1970s and 1990s, especially during the 1980s, evangelical NGOs experienced a dramatic growth in revenue and in market share of the religious NGO sector (McCleary 530). While in 1940 the composition of religious PVOs (in McCleary’s terminology) was 38% Catholic, 25% Jewish, 15% mainline protestant, 7% evangelical and 6% Faith-Founded, by 2004 45% were evangelical, followed by Faith-Founded at 13%, Mainline Protestant at 11%, followed by Catholic, ecumenical, Jewish, Muslim and Orthodox (McCleary 519).¹⁶ This growth can in part be attributed to the integration of Evangelical groups in parachurch organizations that allowed “for fundraising from a broad base of adherents” and, not associated with one specific denomination, allowed them to skirt legal restrictions that disallow denominational private voluntary non-profits from directly soliciting funds from their congregations (McCleary & Barro 2008, 531). Evangelical organizations were also likely helped by the fact that they, in addition to benefitting from the trend that diverted official development aid to NGOs, operated well-honed mechanisms of

¹⁶ McCleary and Barro use the classification “Faith-Founded Christian” to describe an organization “based on religious principles or values but with no formal affiliation with an organized religion” (516). This classification helpfully describes a recent trend among Christian organizations like, most notably, World Vision that while founded with church affiliations have recently transitioned into more neutral, non-denominational Christian organizations. They note, “Faith-Founded Christian category captures a recent change in the religion scene, namely, the rise of agencies that are neither Evangelical nor denominational yet adhere to broad Christian values” (516-517). World Vision’s transition from Evangelical to Christian Faith-Founded, as examined here, occurred during the late 1970s.

individual fundraising and therefore able to take full advantage of the boom in private funding that occurred throughout the 1970s and 1980s. Stoddard notes that while the US public is less inclined than their European counterparts to donate to international aid, of the majority of donations to these causes are raised by Christian faith-based agencies (Stoddard 2003, 29). In fact, the share of federal funding among evangelical INGOs decreased significantly during this period while their overall revenue grew: revenue from federal funding dropped from an average 33% between 1955 and 1967 to an average of 12% between 1968 and 2004 (McCleary 2008, 523).

Evangelical Relief and Development Adapts

The NGO explosion of the 1980s facilitated the merging of the somewhat distinct histories of evangelical and mainstream NGOs as all clamored to partake in the thriving marketplace where annual revenues were now in the multimillions. Nowhere is this dynamic more pronounced than with World Vision and its transition from evangelical to Faith-Founded, from laggard to ranking number 1 among the top 3 of all INGOs since the early 2000s (Stoddard 2003, 28). While throughout the 1950s and 1960s World Vision remained rather independent from the trends affecting the rest of the international development sector, it did have a board of directors. Beginning in the late 1960s the board sought to balance the budget and position World Vision in such a way that it could partake in the massive revenues of mainstream INGO market. The directors found that, while the emotional appeal of individual charity model and child sponsorship was highly effective in generating donations, the accompanying spontaneity that characterized Pierce's management style was not. The idiosyncrasies of Pierce's leadership, driven by sincere faith and a belief in miracles—it was not uncommon for him, for example, to

promise funding to someone on the spot on the power of prayer, regardless of existing funds—left World Vision in debt. Under the management of the board World Vision began accepting government funds and, in a departure from the spontaneity of Pierce’s style, endeavored to demonstrate efficacy and impact. Pierce, dissatisfied by what he saw as the abandonment of the organizations evangelical roots, left World Vision in 1967, founding Samaritan's Purse, an organization that put “evangelicalism first and humanitarianism second” and is now run by Franklin Graham (Thaut 2009, 343).

Peirce was replaced by Walter Stanley Mooneyham, who, although a charismatic and committed evangelist, shifted the organizational structure and re-focused on internationalizing the project, moving away from Korea and China and toward Africa and South America in line with the rest the sector. The nature of its work also changed somewhat, turning toward more mainstream relief and development projects (VanderPol 2010). These changes along with participation in high profile crises in Africa specifically allowed World Vision to participate in the mainstream NGOs’ fundraising boom, receiving increasing funds from private and public donors. Per David King, World Vision’s participation in aid efforts related to the highly publicized 1984 Ethiopian famine saw its income jump eighty percent in one year, raising funds “faster than it could create programs to spend them” (King 2012, 937).

This gradual identity shift lent World Vision new, and very profitable, legitimacy in the world of international aid. It allowed World Vision access to both federal USAID funding and appeal to a broader base of individual donors, secular and religious alike, who might have been turned off by its formerly evangelizing message. The growing reliance on federal funding encouraged World Vision to “meet greater professional standards for its work” which was felt across the evangelical NGO sector (937). In 1979, evangelical humanitarian agencies working

oversees, hoping to model the profit-making elements of mainstream organizations, founded their own umbrella organization, the Association of Evangelical Relief and Development Organizations. Facilitating professionalization and efficiency it fostered, “technical expertise, mutual support, and best practices among its members while also lobbying for government grants” (King 2012, 937). In other words, evangelical organizations were catching up with mainstream professionalization in ways that opened up floods of new revenue. Between 1969 and 1982 World Vision’s revenue went from 4.5 to 94 million (VanderPol 2010, 109). While new recipients of USAID, private donations still comprised the majority of World Visions funding. Their well-honed approach to media and fundraising centered on child sponsorship, which now incorporated TV advertizing and telethons, remained critical to World Vision’s success through the 1980s and beyond.¹⁷

These trends continued into the 1990s and 2000s. Revenues increased for international relief and development NGOs generally and among evangelical organizations in particular, facilitated in large part by the George W. Bush administration. The 1990s and 2000s have been marked by ever increasing private donations. As Rodger Riddell noted in 2007, “private donations from individuals and foundations topped the 10bn mark, and, since then, the steady expansion of the previous ten years been sustained” (48). All the while the US has continued to funnel significant amounts of foreign aid through NGOs and other private non-profits, more so

¹⁷ Compared to Save the Children US and CARE for which public funding accounts for about half of their funding World Vision continues to receive mostly private funding. This difference is reflected in models and techniques of fundraising with organizations that rely, like World Vision, mostly on private donations—in 2003 80% of their revenue came from private donations and 80% of those donations were from individuals—the largest practitioners of the direct appeal often in the form of child sponsorship (Stoddard 29). Even in 2001 under Bush, federal funds were only 20% percent of World Visions revenue. This is especially stark when compared to CARE, the US-Based NGO with second most revenue, which received 75% of its funds from public sources in 2003 (Stoddard 2003, 29)

than every other developed nation, with around 41% percent going to private organizations in the mid-2000s (McCleary and Barro 2008, 512). World Vision exemplifies this post 2000 growth, as King writes, World Vision’s growth in the 1980s and 1990s “paled in comparison to the expansion in the decade after 2000. In 1995, World Vision International’s budget stood at 300 million dollars. By 2008, it had grown to 2.6 billion dollars” (King 2012, 937).

Mercy Ships came into existence in 1978 just as the evangelical relief and development world began to organize and professionalize and as revenue began to soar. It was able to participate in the ever-expanding INGO market and today Mercy Ships’ organizational structure, mission and self-presentation reflect the neoliberal moment in which it emerged. Like World Vision, Mercy Ships has successfully combined aspects of evangelical humanitarianism with those of mainstream relief and development. Mercy Ships’ language is distinctly Christian but stops short of directly evangelizing. Financially, it relies, even more so than contemporary World Vision, on individual donations. While Mercy Ships does not offer child sponsorship programs, its approach, showing the transformed faces of disfigured unspecific “African” children, is indebted to World Vision’s approach. However, it is important note that this approach is popular among international relief and development organizations of all types. Most mainstream and left-leaning organizations similarly rely on stories of suffering, albeit some are less inclined to utilize graphic photos.¹⁸ Mercy Ships, however, engages in a more extensive direct mailing campaign

¹⁸ The utilization of tragic stories is standard practice for all major INGOs (CARE, Save the Children, etc.). Smaller left-leaning organizations also make use of this appeal. The Center for the Victims of Torture, for example, presents stories in a style similar to Mercy Ships, albeit with less graphic images (see: <https://www.cvt.org/what-we-do/survivor-stories>). However, there is variety in these approaches. As Rozario notes, “In recent years, some charitable institutions have begun to react against the saturation coverage of violence and misery in movies, news broadcasts, television shows, and magazines, declaring an intention to resist making spectacular appeals. Oxfam, for example, has moved to head off compassion fatigue by announcing a

than most. While they have fairly positive ratings from charity assessment boards, their fundraising budget accounted for 16% of their expenses in 2017, almost double most comparable organizations. It is, in other words, highly exposed to the market and highly reliant on the solicitation of the individual contribution. Parallel to the political history of parachurch missions and evangelicalism, it shies away from complex structural critiques of poverty. Its central activity, the delivery of surgery, fits within longer-standing evangelical traditions related to the administration of physical healing and embrace of Western medical technology. However, in this respect, Mercy Ships' medical humanitarianism in West Africa is indebted to a longer history: the colonial medical mission.

Christian Medical Missions and the Pathologization of Africa

Although Mercy Ships has worked in over sixty countries, in the past two decades its efforts have been directed primarily at the West African coast. This geographic focus is reflected by its fundraising materials that exclusively feature photographs of black West African men, women and children, typically those with visible disabilities and physically manifest health issues such as facial tumors and cleft palates. The medical nature of Mercy Ships' project, its Christian character and focus on West Africa places it within the tradition of the medical mission to continental Africa, both in form and ideology. While Mercy Ships works primarily in West Africa the history of medical missionaries discussed here applies broadly to Sub-Saharan Africa.

Christian missions from Europe were on the vanguard of the colonialist project in Africa. Early missionary ventures were understood as humanitarian "missions to the suffering" and by the 19th century Western medicine was integrated into this project (Comaroff 1993). The

principled refusal to subject potential donors to 'heart-rending photos calculated to play on your emotions'" (443).

concept of the medical mission corresponded with Christian theological accounts of suffering that understood bodily affliction as directly linked to the spiritual and moral afflictions suffered by non-believers. In this context, missionaries saw the delivery of medical care not only as a way to connect with local communities but also as a project modeled directly on Christ's healing miracles (Ranger 1992, 257). However, while the connection between spiritual and bodily salvation was based in Christian theology it was also premised on racialized imperialist logics. Missionary medicine was part of a moral economy that understood sick bodies as evidence of spiritual and moral degradation, concepts that hinged on notions of civilization and race (Vaughan 1991; Livingston 2005). Influenced by environmental conceits of 18th century humoral medicine, Europeans viewed the climate of the African continent as dangerous to one's moral character and a site of pathology. The alleged heathenism and primitivity of Africa and its people, placed in opposition to the civilized Christianity of Europeans, was understood as at the root of social ills, ill health included, and medical missionaries saw their joint practice of spiritual and physical healing as a project through which Africa would be saved (Comaroff & Comaroff 1997).

The emergence of modern biomedicine over the course of the 19th century had a profound effect on medical missions as it did on the colonial project as a whole. "Cut from the same cloth," as Jean Comaroff writes, biomedical science and imperial expansion, particularly into the African continent in the late 19th century, were deeply interrelated as at the core of each was a constructed racial hierarchy that placed white Europeans in a position of "natural" domination (Comaroff 1993, 306). Longstanding racist imperialist ideas took on new strength as they fashioned themselves around emergent biologic rationales and falsely constructed taxonomies that sought to establish a biological basis of race. Existing racist beliefs regarding the

primitivity and degeneracy of Africans were re-iterated through falsely applied evolutionary conceits. The low status that Africans were assigned on the racial “ladder of civilization” revolved centrally around the notions of physicality and racial difference projected on black bodies, and therefore had a particular relationship to medicine (Comaroff 1993, Vaughan 1991).

Christian medical missionaries readily grafted racist biomedicine onto a belief system that had long linked the sinful soul of the African non-believer to ill health, “what was formerly couched in terms of Christian well-being came to be spoke of in the assertive language of science” (Comaroff 1997, 325). While the image of the “healthful native” persisted (racist bioscience was in no way consistent) racist characterizations of Africans revolved around ascriptions of degeneracy, uncleanness and contagion, concepts understood as at once moral and medical by medical missionaries as they were by scientific, popular and political discourse of Western colonial powers. So with the ascendancy of scientific racism, healing on the colonial frontier, Jean Comaroff argues, was a useful “technique of civilization” that “carried with it a pervasive philosophy about health and contagion, propriety and degeneracy; about the relationships of bodies and contexts, matter and morality” (Comaroff 1993, 315).

In this context, while by the early 20th century a missionary doctor might no longer directly attribute physical afflictions to the sinful soul, Christian views on illness were transposed onto the newly emergent biomedicine through recourse to racist assessments of African culture and tradition. Racialization continued to underwrite assessments of physical health through terminology of “the native habit” well into the 20th century, becoming enmeshed with developing biomedical concepts. In 1909, for example one missionary doctor, taking up concepts from bacteriology, linked pulmonary illness in children to the “traditional” manner in which children were carried and their clothing that left damp areas open to bacterial growth (Comaroff

1993, 315). In fact, the significant medical developments of early 20th century presented a special opportunity for medical missionaries who understood Western medicine's advancements akin to Christ's miracles.

In this sense 20th century medical missionaries were somewhat distinguished from other colonial actors, which by this time had established colonial states across the African continent and with them public health apparatuses. While, during the interwar period colonial public health officials and others began to attribute ill health, like increasing infant and maternal mortality rates in East and Central Africa, to de-culturation and loss of traditional practices, a view with its own racist implications, medical missionaries resisted this analysis. They remained committed to the belief that Christianity and the West were the solution to all social and health woes and rejected the idea that "traditional" practices, midwifery and birth spacing for example, could have a positive effect on health. While these issues were in fact caused by the poverty induced by the violence of the colonial project, medical missionaries attributed high rates of infant mortality and malnutrition to pathologies of "primitive" family structure and the lack of a nuclear Christian family unit (Vaughan 1991, 68; Hartmann 1995, 41). In this respect, medical missionaries saw the administration of medical care, in an even more direct manner than colonial states, as part of their moral imperative to pull Africa into Christianity and civilization. As Megan Vaughan writes, "healing for medical missionaries was part of a programme of social and moral engineering through which 'Africa' would be saved" (Vaughan 1991, 73).

While medical missionary projects to Africa in the late 19th and early 20th century were in some ways distinct from the colonial state, they had also, ideologically and materially, abetted the European occupation and colonization of Africa. Medical missions provided cultural, infrastructural and economic inroads useful for the colonial take-over and the establishment of

states (Comaroff 1985). In a larger sense, medical missions, and the provision of medical care generally, served as a primary justification for colonial rule in ways that resonate with contemporary humanitarian aid. The administration of Western medicine, antibiotics, vaccines and so on, was considered by many in the West to be at least one objectively good component of the colonial project and medical humanitarianism proved highly effective in cloaking colonial and imperialist violence. The white missionary doctor was viewed as heroic back home, often cast opposite the figure of the suffering and objectified African in popular and humanitarian fundraising literature (Vaughan 1991, Comaroff & Comaroff 1997). In this sense, medical missions to Africa served as both a justification for colonialism and as a site of where the Western science, civilization, culture and religion, could not only be demonstrated as superior but also as morally good in ways that continue to impact and imbue humanitarianism in this region.¹⁹

Mercy Ships: Contemporary Medical Mission

While the operations of medical missions were largely overtaken by colonial public health apparatuses and then by independent African states, the legacy of medical missions to Sub-Saharan Africa is carried on in part by contemporary humanitarian NGOs, religious and secular alike. As newly independent African states underwent transitions and crises in the 1980s, independent medical missions and medical NGOs filled in the gaps as medical missions had in past centuries. American evangelical groups and its parachurch missions were particularly

¹⁹ The cultural, infrastructural and economic inroads medical missionaries made proved useful to the colonial state and Western medicine provided by missionaries served as an early “civilizing commodity,” which ushered communities in Africa into the marketplace (Comaroff 1993, 319). Established missionary hospitals were taken over by colonial public health departments allowing colonial states access to communities and a conduit through which to implement objectives related to health and population.

enthusiastic inheritors of this tradition. Like medical missions, American evangelical INGOs that provide medical care, like World Vision and Mercy Ships, consistently figure Africa as a site of pathology and Western medical technology as an agent of Christ-like salvation, “emulating Jesus’ healing ministry through making use of the best medical technology” (VanderPol 2010, 84). Although Mercy Ships has today moved away from this language, they have consistently described their work in biblical terms. Their surgeries allow “the blind [to] see (cataract operations), the lame [to] walk (orthopedic operations), and the mute [to] speak (cleft lip and palate operations)” (Lange 2015, 24). As Don Stephens said in an address to an evangelical congregation, “I think the closest I’ve ever come to what I think it would be like to have been one of the 12 disciples following Jesus is when someone received their sight for the first time like in blind Bartimaeus” (Lecture: Don Stephens on Miracles 2018).

Like the 19th century medical missions, contemporary evangelical medical relief projects tend to lack nuanced socioeconomic analysis and often center a contemporary version of cultural pathologization. While Mercy Ships does cite poverty as the central cause of the health issues it treats, as Don Stephens for instance calls them “the diseases of poverty,” poverty is defined vaguely and cultural factors are emphasized. For example, Mercy Ships typically highlights the social rejection experienced by its patients. One typical story is that of an adolescent African boy, Victorien. While up until the age of 10 “a happy child living a normal life,” when a tumor “the size of a grapefruit” grew on his face, the text goes on: “Suddenly Victorien was shunned by friends and neighbors. People called him cruel names. Kids refused to play with him, and his teacher asked him not return to school” (“Watch Mercy Ships Change a Life—See Victorien’s Story”, 2019). Although not attributed to the sinful soul, Africa is pathologized through an apparently cruel culture that shuns Victorien. This is put in comparison to the judicious and

benevolent West: “If Victorien lived in America, his tumor would have been removed. But he was born into poverty in Madagascar, where very few have access to safe affordable surgical care.” Very much as in colonial medical discourse, Africa is portrayed as superstitious and irrational. As described in their 2013 60 Minutes feature, “[Africa Mercy] is also the closest thing to a time machine that you’re ever likely to see. Her largely American crew brings 21st century medicine to people who believe that illness is caused by evil spirits. The patients’ beliefs may be archaic but their courage is to be admired. They suffer from diseases unseen in America, illness that can make you believe in curses” (“Africa Mercy: Hospital of Hope” 2013).

Mercy Ships’ approach to medical care and inheritance of the medical mission is also influenced by the neoliberal moment in which it emerged and evolved. Unlike medical missions that often established important medical infrastructure, Mercy Ships’ style of aid, the provision of surgeries on a self-contained traveling vessel, is minimally invested in long-term development or infrastructure. While programs for “Lasting Impact” are featured on Mercy Ships’ website, the majority of its work is comprised of surgeries, surgeries at that which are the easiest to market. With respect to its reliance on individual contributions and its style of fundraising, the removal of facial tumors and cleft palate surgeries photograph well, allowing for a convincing before and after shot. They appear the most miraculous, literally transforming disfigured faces into smiling ones. In this way, one could describe Mercy Ships’ approach as a neoliberal Christian medical mission.

It should be reiterated that while Mercy Ships engages in a particular evangelical inheritance of medical missions, as will be discussed here with respect to obstetric fistula, racist monolithic characterizations of Africa as backward and barbaric are in no way particular to Mercy Ships. This logic, in various iterations, operates broadly across the “Western”

international humanitarian health networks in the developing world.²⁰ In this sense, just as it is important to point out how medical humanitarianism participated in the colonial project and the racist construction of Africa as primitive and degenerate, it is equally salient to unpack how medical humanitarianism projected certain “Africans”, usually women and children, as victims of this culture and its men and white men, and white women, as their saviors.

Saving “Other” Women: Western Colonialist, Imperialist and Humanitarian Interventions

The third back story necessary to understanding Mercy Ships, Shannon Ethridge and fistula repair is the history of the gendered, racialized and sexualized project of “saving” women in Western colonialism, imperialism and, arguably, Western-led humanitarianism. The pathologization of indigenous culture and people relied in many ways on logics that posited some colonial subjects as victims of the barbaric, static and backward culture and therefore on the positive affect of sympathy or pity. In fact, as Kyla Schuller elaborates, this framework of sentiment, in which humanitarianism functions, was itself a racialized one. The ability to be properly affected—one’s impressionability with respect to “cultural progress,” physical pain or the suffering of others—was positioned as the exclusive domain of the “civilized” (white) subject.²¹ In this sense humanitarianism can be problematized not only for the ways in which such projects pathologized indigenous populations and geographies, but also for the ways in

²⁰ For examples see discussions of “female genital mutilation” from many women’s rights organizations, like the Global Alliance Against FGM and UK-based 28 Too Many, the logo of which is the outline of the African continent and which describes FGM as a “harmful traditional practice” aimed at, among other things, the preservation of virginity and family honor. For a critique of FGM discourse see Ahmadu and Shweder (2009).

²¹ She writes that while understandings of affect typically see the ability to be affected and to affect as one “seamless whole” the discourse of impressibility in 19th century discourse points us to the idea that “Within biopower, racialization and sex difference do the work of unevenly assigning affective capacity throughout a population” (Schuller 2018, 13).

which it created the victims upon which the heroic act of saving relies. Specifically here, just as Mercy Ships can be understood as an inheritor of the medical mission in Africa, its fistula program indicates its inheritance of a specific argument employed by colonial powers: the saving of colonized women from the patriarchal violence of colonized men.

The portrayal of certain colonial subjects, in Africa and elsewhere, as victims of some aspect of local culture or practice in order to justify Western intervention was endemic to the colonial project and, most often, was tied to interrelated practices of racialization, gendering and sexualization. Well documented by the work of Ann Laura Stoler and others, colonial powers utilized sexual and gendered logics flexibly, often conflating “racial category, sexual morality, cultural competence and national identity” (198). As Antoinette Burton notes, colonial agents often pathologized indigenous culture by reference to the “sexualized” body – with sex holding, as Stoler also observes, a primary place in biomedical and eugenic logics of 19th-century colonialism (Burton 2005, 8). As Stoler writes, colonial discourses influenced by Lamarckian models “linked racial degeneracy to the sexual transmission of cultural contagions and to the political instability of imperial rule” (Stoler 1996, 234). In the changing power dynamics of colonial rule, the constructions of the colonizer and colonized upon which imperial authority was legitimated were not stable. Rather, as Mrinalini Sinha writes, the constructions had to be secured via gender and race, “through various policies and practices that constructed and regulated particularly, historically specific gendered, and racialized identities” (Sinha 1996, 480). Critical race theorists have described these as dual processes of “sexualization of racism” and the “racialization of sexism” (Hernton 1992; Davis 1983; Braxton 1973; Fanon 2008 [1953]). As Sara Farris puts it, racism is “sexualized insofar as the racist imagery operates through powerful sexual metaphors and desires” and sexism is racialized as “racism operates through the portrayal

of sexism and patriarchy as the exclusive domains of the (non-western and Muslim) Other” (73).²²

In this context, interdependent colonial projects of gendering, racialization and sexualization were diverse, employed flexibly in a range of historical moments throughout the many geographies of Empire. While one example was the projected, often sexual, threat of especially black male colonial subjects on *white* women—the false idea that white women were under constant threat of rape by African men constituted colonial sex panics in Southern Rhodesia and elsewhere in colonized Africa— there was also a discourse that figured colonized, racialized male subjects as a threat, sexual and otherwise, to colonized, indigenous women. (Stoler 1996, 229; Philips 2005, 102). Arguments that feature a colonial women subject threatened by colonial men, both through physical violence and more generally through the backward patriarchal systems they upheld, is a hallmark of colonial discourse and of particular interest to this discussion of obstetric fistula.

This particular configuration, to put it directly as Gayatri Chakravorty Spivak does in “Can the Subaltern Speak?” is one of “White men saving brown women from brown men” (Spivak 1994, 92). Characterized by the dichotomy of modernity and primitivity, this sexualized and gendered colonial narrative centered on the portrayal of indigenous culture as specifically violent against women. It was wrapped up in the West’s project to distinguish its itself as the exclusive site of socio-cultural progress and depict colonial possessions as, per Uma Narayan, “entities paralyzed by Tradition, cast either as static and inert or in a process of ‘decline’” (Narayan 1997, 16). It created specifically cultural conflicts between Western colonizing and colonized indigenous cultures and in this sense often involved “issues pertaining to women’s

²² For further discussion see roundtable on Scott’s *Sex and Secularism* (Fuji 2018).

roles, and female sexuality” (Narayan 1997, 17). As Narayan states, “rendering the figure of the ‘Colonized Woman’ was an important site of the political struggles between ‘Western Culture’ and the ‘Culture’ of the colony” (17). Colonial powers selectively concerned themselves with the plight of women, utilizing images of victimized colonial women, characterized as helpless and childlike. The “threat” of indigenous men was invoked in order to justify colonialist interventions, legal and military, and, like the medical mission, the “civilizing” project as a whole (Abu-Lughod 2002). This discourse relied on positioning gender violence as something distinctly other to the West, patriarchy and oppression something located in these uncivilized other cultures (Narayan 1996).²³

The deployment of the “woman question” was widespread in colonial discourse across the globe. Examples include colonial campaigns against polygamy, in indigenous cultures in Canada, Africa, South Asia and the Middle East, child marriage, in India and Africa in particular, and *sati* “widow burning,” in India (Carter 2008; Sinha 1996). Revolving around issues of indigenous “culture” they also helpfully and effectively diverted attention, argue Sinha and others, from material conditions and destruction wrought by colonialist intervention and violence. She writes of colonial India that “topics like child marriage became a site of this discussion with historical and material conditions ignored in favor of an assessment of Indian culture” (481). The indigenous women under discussion were effectively silenced, objectified and infantilized. “Merely the sites” as Sinha explains with respect to debates surrounding *sati* in India, “on which competing views of tradition and modernity were debated” (481). The West’s

²³ As Kyla Schuller notes, the projected brutishness and uncaring attitude of colonized men in these narratives was related to somatic notions of the racialized body, their projected cultural backwardness linked to an allegedly insensitive body. Inert, unfeeling, they were considered “animated fossils of the evolutionary past” unable to be properly moved by both the civilizing project and by pain of others (Schuller 2018, 57).

men and women, defined specifically with respect to the tenets of bourgeois femininity, were depicted as forces of modernization that would pull backward indigenous culture from the dark ages and into a more equitable society, “saving” women from patriarchal oppression and the deviant sexuality of colonized men.

Critically, while notions of proper womanhood were of course inscribed by the patriarchal notions of the colonizing power that, during the 19th century, revolved around the bourgeois Victorian ideal of female domesticity and motherhood, they still earned the support of Western feminist women (Ahmed 1992 150-151, Sinha 1996). Leila Ahmed has termed the co-option of feminist language in order to defend colonial interventions and rule and the participation of white colonialist women in these efforts as “colonial feminism” (L. Ahmed 1992, 150). In this sense, while in some ways colonial powers could be described as co-opting woman’s rights language such a reading underestimates the extent to which these issues, child marriage, widow burning and others, were the genuine concerns of white colonialist feminists and, additionally, ignores the complex ways in which colonized women subjects navigated these debates (Sinha 1996, 479). In this sense, while there was at times convergence between colonial and indigenous patriarchies, there was also convergence between imperialist feminism and male imperialist patriarchy.

These dynamics persist today in a number of contexts. As scholars Leila Ahmed, Lila Abu-Lughod and Sara Farris have explored, the use of the “woman question” has been particularly enduring with respect to Islam, both in justifying contemporary military conflicts and in discussions of the “assimilation” of Muslim populations within Western nations. The “liberation” of Muslim women from the allegedly patriarchal structures and traditions “inherent” to Islam, from polygamy to veiling, has proven to be an effective rhetoric from the early days of

colonization in North Africa through the Algerian War, and the 2003 invasion of Iraq, all conversations in which some white feminists enthusiastically joined (Nayak 2006; Al-Saji 2009; Abu-Lughod 2002; L. Ahmed 1992; Farris 2017; Shepard 2006). In addition to a convincing rhetoric for military intervention, scholars have explored the extent to which the figure of the oppressed Muslim women functions as a sleight of hand that for conditions inside Western nations, defining sexism through the process of racialization as something by definition other. As Al-Saji writes of contemporary discourse surrounding Muslim women, “representations of veiled Muslim women are the negative mirror in which Western constructions of national identity and gender can be positively reflected” (69). Images of oppressed racialized women, per her reading, function to divert attention from patriarchal conditions at “home” and make the figure of the Western woman, defined here by comparative sexual and bodily liberation, legible and coherent (69).

In addition to the justification of military interventions in Muslim majority countries, this racialized discourse on the liberation of women also functions predominantly in Western-led humanitarianism and international relations. Colonial discourses that selectively took up the cause of women when tied to “cultural” issues like *sati*, child marriage, polygamy and other practices, are represented by contemporary issues, many of which are in fact identical or nearly so. Some prominent examples include early marriage, human trafficking, female genital mutilation or cutting and, as will be explored here, obstetric fistula. These issues figure prominently in the discourse of international relations and global health coming from the US in Europe and many come to be *causes du jour* for international NGOs. They proliferate on Western media, the subject of journalism, documentaries and TV specials. As Vance discusses with respect to discussions of sex trafficking, these cultural gender issues continue to be framed

in terms of melodrama, with easily identifiable victims and villains in ways that correspond with patterns of racialization. Like colonial invocations of women, they work, writes Vance, to “divert attention from larger structures of exploitation (Vance 2011, 136).

Even gender issues once primarily domestic, like the “white slave” sex trafficking crusades of late 19th- century America, have moved into international and now differently racialized contexts. As Vance notes, recent conversations and cultural portrayals of forced prostitution and sex-trafficking focus overwhelmingly on women in the global south (Vance 2012, 200). These issues, now often framed as issues of global health, continue to rely on the portrayal of the cultural and racial Other, the construction of racialized male villains, and the objectified and infantilized female victim. And, like these past iteration of the “the woman question” in colonial discourses or in sexual morality panics like those related to prostitution in the late 19th century, they continue to, as Vance writes, provide a “capacious home for reactionary and progressive impulses” alike (200).

With this history in mind, humanitarian rhetoric that features racialized women in need of saving should be treated critically – both in that it may be an example of the co-optation of women’s rights language by patriarchal forces and to the extent that the endorsement of Western feminism should be treated, in light of this history, with caution. A cover for colonial incursion, a critical component in the processes of racialization, and a useful sleight of hand to distract from sexist conditions at home, this call to save women can in contemporary contexts also be considered as a cover for neoliberal expansion. In the economic and political context of the modern NGO, as the next section will explore with respect to Mercy Ships’ fistula repair program, these racialized, sexualized, gendered stories function as sites of revenue generation, the center of the fundraising strategies upon which these organizations existentially rely, and

demonstrate the enduring appeal of the call to “save brown women from brown men” to evangelicals and Western feminists alike.

OBSTETRIC FISTULA: RACIALIZED *CAUSE DU JOUR* IN GLOBAL HEALTH

Mercy Ships’ Fistula Repair Program and Involvement with USAID and EngenderHealth

Vesicovaginal fistula (VVF) is an injury that occurs in prolonged and obstructed labours during which the extended pressure from a child’s head on a woman’s soft tissue causes an abnormal pathway to form between the vagina, rectum and/or bladder. These labors lead to stillbirth in an estimated 85% of cases and the rupture, or fistula, often results in chronic incontinence, the leaking of urine and fecal matter into the vagina, and the inability to bear more children in addition to a host of secondary ailments including “foot drop, bladder and kidney infections, limb contractures, or excoriation from the skin’s constant exposure to urine or faeces” (S. Ahmed and Holtz 2007; Heller and Hannig 2017, 81). Once a relatively common childbirth injury, obstetric fistula was largely eliminated in the developed world with the advent of modern obstetric care and access to emergency c-section. It remains widespread in parts of the developing world, like sub-Saharan Africa and South Asia that lack basic obstetric healthcare and infrastructure, affecting an estimated one million women globally. The surgical repair of VVF—the first replicable and effective surgical iteration widely credited to controversial American obstetrician Dr. Marion J. Sims who developed the procedure on enslaved African American women—repairs the rupture in the vaginal wall and today is done mostly laparoscopically (Owens 2017).

Mercy Ships began performing vesicovaginal fistula repair surgery in West Africa in 2001 at the request of the government of Sierra Leone. (“Program Background – Fistula Care Plus”). Partnering with Sierra Leonean government, likely with some funding, Mercy Ships began performing repair surgeries and helped to found the Aberdeen Fistula Center, now Aberdeen Women’s Center, located in Freetown; it opened in 2005.²⁴ Although Mercy Ships is not typically, by all available tax documentation and literature, the recipient of US federal funding, VVF surgery appears to be one exempted area. In 2007 Mercy Ships began a partnership with the Fistula Care project, a USAID fistula repair and prevention initiative managed by EngenderHealth that operated from 2007 to 2013. With USAID support, Mercy Ships performed over 300 VVF surgeries aboard the *Africa Mercy* and the now retired ship *Anastasis* stationed in ports in Benin, Ghana, Liberia, and Togo and trained roughly 10 medical professional in fistula repair surgery. Mercy Ships’ involvement with the Fistula Care project ended in 2010. Tax records from 2006 show revenue from “government grants” for the first time: Mercy Ships received \$579,156 in 2006, \$523,685 in 2007, and similar funding thereafter until 2011, in which they received a final payment of \$266,421, after which they have not reported federal grants.

This marks, by all appearances, an odd alliance. Given the relative historical independence that Mercy Ships, like other evangelical organizations, have had from USAID and the hostility of the conservative American evangelical culture to the programs typically a part of reproductive health initiatives, it is, to put it mildly, peculiar that Mercy Ships would be the recipient of funding from sources invested in the advancement of reproductive and sexual health.

²⁴ Aberdeen Women’s center is now managed by The Gloag Group, a charity of Ann Gloag, the fourth richest woman in the UK and famous Nazarene evangelical. (“Sierra Leone – Fistula Care Plus” n.d.).

Notably, its partner Engenderhealth, an independent non-profit headquartered in New York City, describes itself as a “Leading global women’s health organization committed to working toward a world where sexual and reproductive rights are respected as human rights and women and girls have the freedom to reach their full potential” (EngenderHealth “Who We Are”).²⁵ It is led by self-described “life-long advocate for the rights of women and girls” Ulla E. Mueller, a voice in international women’s health who writes on these topics for The Huffington Post and elsewhere, advocating strongly for access to contraception and abortion. EngenderHealth first began working on obstetric fistula in 2001 in collaboration with the Women’s Dignity Project, a Tanzania-based fistula repair and prevention program that operated from 2002 to 2013, and the United Nations Population Fund, a program that supports a wide range of reproductive health and family planning initiatives, committed to the advancement of gender equality in accordance with the UN’s 1994 Programme of Action of the International Conference on Population and Development agreed to at the 1994 Cairo conference. EngenderHealth’s partnership with USAID, which began in 2004 and included a five-year Associate Cooperative Agreement to create the Fistula Care project, went through USAID’s ACQUIRE project, of which

²⁵ EngenderHealth’s ratio of government to private funding illustrates how it differs from Mercy Ships, with respect to both financial structure and culture. In 2011, the earliest 990 form available, EngenderHealth’s revenue from government grants was \$46,353,388, while its revenue from private donations was \$13,054,128; much of its funding was then distributed as grants to smaller non-profit organizations, mostly in Sub-Saharan Africa. While Mercy Ships’ and EngenderHealth have similar management salaries (around \$200,000 to \$300,00), EngenderHealth’s CEO earned \$161,843 in FY2017 plus \$20,398 in “additional compensation” while Mercy Ships’ President Don Stephens made \$293,187. While EngenderHealth has a larger management team that make upwards of \$150,000 a year (EngenderHealth’s combined employee salaries and benefit expenditure totals \$26,560,765 while Mercy Ships’ totals 13,174,354), EngenderHealth unlike Mercy Ships, spends no money on professional fundraising services. In FY2017, Mercy Ships paid the Russ Reid Agency \$1,636,864 for fundraising services and, remarkably, reimbursed Russ Reid for print and mailing fundraising expenses in the additional amount of \$6,741,195. It’s unsurprisingly then that fundraising accounted for around 16% of Mercy Ships’ total expenditure in 2017. (All information sourced from the organization’s 2017 909-tax forms available on their websites).

EngenderHealth was a managing partner. ACQUIRE, which stood for Access Quality in Reproductive Health, in operation from 2003 to 2008, was a global cooperative agreement supported by USAID for the express purposes of advancing and supporting “the availability, quality, and use of facility-based reproductive health and family planning services at every level of the healthcare system” (EngenderHealth “The ACQUIRE project). Among its stated goals, according to its archived website, was to “integrate family planning services with HIV, maternal health and postabortion care services” (EngenderHealth “The ACQUIRE project).

It is not surprising then that Mercy Ships, with its history and ideological orientation, did not, at least through available archived web pages, advertise nor even mention its relationship with USAID, the Fistula Care Project and EngenderHealth even while it prominently featured its fistula repair work. Today, although Mercy Ships no longer works with outside fistula programs, VVF repair remains a central part of its health program and presentation, allowing it to claim active participation in a “women’s health” program. In light of these contexts, how can we make sense of the temporary partnership, from 2007 to 2010, between Mercy Ships and EngenderHealth, and the fact that obstetric fistula appears to be an area of overlap between NGOs with such different fundraising structures, agendas, donor bases, self-presentations and that operate in somewhat different worlds, especially with respect to issues of reproductive and sexual health? In what context in the early 2000s did Mercy Ships begin featuring fistula repair in its distinctive fundraising and advertising method? Why in 2007 was it reasonable that Mercy Ships would partner with EngenderHealth for this USAID funded reproductive health program?

USAID under George W. Bush

One critical context was the presidency of George W. Bush and his administration's management of USAID, as it was during this period that the 2007 partnership of Mercy Ships with the Fistula Care Program was put into action. Under his administration, as data from McCleary and Barro show, evangelical NGOs flourished and received increasing federal funds, many for the first time. At USAID, meanwhile, measures were enacted that expressly curtailed the ability of federally funded international NGOs to engage in certain programs related to sexual and reproductive health. The Bush administration's approach was especially evident in the President's Emergency Plan for AIDS Relief (PEPFAR), a 15 billion dollar commitment to addressing the global epidemic established in 2003. Heated debates erupted over how this money should be distributed and to what projects, with conservative lawmakers and administrators effectively limiting funding for condom distribution, which they framed as encouraging of immoral promiscuity. In the end only 20% of the PEPFAR budget was dedicated to prevention and within that restrictions were placed on condom distribution as prevention was defined by the ABC approach: Abstinence, Be Faithful and Condoms. Sexual health initiatives were further restricted by one congressional amendment that effectively limited the ability of foreign-based NGOs to engage in HIV/AIDS prevention programs for sex workers by requiring them to sign a "anti-prostitution and anti-sex trafficking" letter, equating these two practices under the banner of the protection of women and girls from "degradation" and "slavery" (Herzog 2008, 130).

Beyond PEPFAR, the Bush administration also pulled out from multilateral forums related to population, sexual health and reproduction in particular, withholding 3.4 million from the UNFPA and 200 million from programs in support of HIV/AIDS prevention, sexual and reproductive health in Afghanistan in 2002 (Hofer 2003, 381, Barton 2005a). As Hofer notes, they did so in order to seek an "independent approach to population policies [...] on the pretext

that UN population programmes would promote abortion and promiscuity” (382).²⁶ Funds intended for these UN-run reproductive and sexual health programs were redirected in large part to religious and faith-based NGOs, especially the larger more mainstream agencies (Hofer 2003, 382). While many smaller faith-based organizations “remain[ed] skeptical about government funding as they fear[ed] it could undermine their autonomy” and preferred not to rely on revenue tied up in partisan agendas, larger faith-based organizations that were already on the government pay roll, World Vision and Samaritan’s Purse for example, were well positioned to participate in this “scheme” (382). World Vision, for example, received 1.3 million from USAID during this period for projects targeting infant mortality and maternal health in Kenya and were under no mandate to provide abortion (Hofer 2003, 382; Kerr 2007).

In this context, it is reasonable that the USAID partnership with Mercy Ships and focus on obstetric fistula functioned to divert USAID funds allocated for reproductive and sexual health from more “controversial” reproductive health initiatives such as access to abortion or sex education. Such a reading is supported by the fact that Kent R. Hill, a conservative evangelical Nazarene, was appointed by George W. Bush to USAID as Assistant Administrator of the Bureau for Global Health, serving from 2005 to 2009. With only a PhD in Russian History, during his tenure as assistant administrator he oversaw programs that addressed HIV/AIDS, such as PEPFAR, as well as programs in maternal and child health, family planning, environmental health, and nutrition. Obstetric fistula, apparently, was a major concern of his. In 2005 he wrote a letter to the editor of the New York Times in response to an article on obstetric fistula in Africa in which he declared USAID’s financial and ethical commitment to this issue. Obstetric fistula also occupied a prominent place in his April 18, 2007 speech to the congressional Subcommittee

²⁶ For further discussion, examples and documentation see Hofer (2003), p. 381-383.

on State, Foreign Operations, where he presented on Maternal and Child Health and Reproductive Health Programs generally and in which he made the case for the fusing of Maternal and Child Health (MCH) and Family Planning and Reproductive Health (FP/RH), to “integrate our programming to the fullest extent possible.”²⁷ After leaving USAID in early 2009, Kent Hill went on to work with World Vision, as well as with the renowned, conservative Templeton Foundation and the Religious Freedom Institute – the latter of which advocates, among other things, on behalf of employers that deny access to contraception to their employees under the ACA mandate (Bowman 2014). In short, this wider context inevitably facilitated Mercy Ships’ involvement with the Fistula Care Project and its USAID funding. Most importantly, it points to the extent to which fistula as a “reproductive health” issue might prove particularly useful to those looking to re-direct money from sexual and reproductive health programs which this administration opposed.

However, to think of fistula repair as simply a component of a conservative strategy to sideline aspects of sexual and reproductive health and make convenient claims to “women’s health” would be to overlook how obstetric fistula was utilized, in an identical fashion, among organizations and international development agendas across the full span of the political spectrum. In this sense, preoccupation with fistula reflects a broader problem noted by critics regarding the ways in which “women’s issues” have functioned as a diversion of energy and funds, not from reproductive health specifically, but from structural economic issues more generally. As Hester Eisenstein argues, “the ‘development’ of women has become a substitute for state-led economic development in Third World countries” and this has been much to the overall detriment of women in these parts of the world (Eisenstein 2009, 136).

²⁷ In this testimony, Hill does advocate for family planning but does so through the central claim family planning programs, including contraception, reduce abortion.

Beyond Bush-era USAID management, the participation of progressive EngenderHealth and the continuation of this program well into the years of the Obama administration, points to the presence of broader dynamics within global health rhetoric and practice.²⁸ Obstetric fistula as a cause is in fact championed by women's rights and health advocates across the international relief and development world. The article that Kent R. Hill responded to in the *New York Times* points to the interconnectedness of these worlds. The article, penned by Pulitzer Prize-winning journalist Sharon LaFraniere, describes fistula sufferers as "would-be mothers, their insides wrecked" and as "too ashamed even to step out of their huts." It ends with the line, quoted from a "6 foot 4" Dutch fistula repair surgeon: "'To be a woman in Africa," Dr. Waaldijk said as he stitched her last sutures, 'is truly a terrible thing'" (Lafraniere 2005). This problematic and highly racialized language is representative of obstetric fistula repair as presented in media and donor literature broadly, and, critically here, bears remarkable resemblance to Shannon Ethridge's description of African fistula sufferers "as the least sexually confident women in the world."

Indeed, the presentations of the issue of obstetric fistula among liberal and conservative groups in global health circles are in many ways indistinguishable and equally steeped in racist stereotyping. In order, then, to understand more fully the temporary partnership between Mercy Ships and EngenderHealth, the apparent convergence of liberal women's reproductive advocates

²⁸ The continuation of the partnership with Mercy Ships may relate to the broader retention of Bush-era USAID initiatives related to sexual and reproductive health through the initial years of the Obama administration. With respect to PEPFAR, for example, while budgets directed to condom distribution eventually did increase, the telltale ABC language (Abstinence, Be Faithful and Condoms) continued to feature prominently in reports to Congress until 2010. It was only then that language shifted and the prevention budget shot from 22.1% to 30.1% and within this, budget for "other prevention," meaning condoms, finally overtook "abstinence and be faithful" by about 1%. See annual reports to Congress on PEPFAR at: <https://www.pepfar.gov/press/c19573.htm>.

and conservative, anti-choice USAID bureaucrats like those at Mercy Ships, we must look at larger dynamics in global health. Specifically, we must address the context of the rise of “women’s health” as a topic in global health, obstetric fistula as a *cause du jour* in this market that peaked particularly in the mid-2000s, and the ways in which stylized narratives around obstetric fistula sufferers, like others framed as issues of gender inequality, are highly sexualized and racialized. Obstetric fistula presents an example of how certain strategies, issues and frameworks related to women’s rights and health traverse the spectrum of western-based INGOs, whether they be faith-founded or secular, self-identified as liberal or as conservative, and the extent to which centuries-old racialized logics regarding the cultural pathology of contexts outside “the West” and the call to “save” colonial women have been transformed by the neoliberal contexts in which NGOs operate.

Ascendancy of Women’s Rights and Gender Equality in International Relief and Development

Obstetric fistula as a *cause du jour* in global health is related critically to the growing prominence of “women’s issues” in global relief and development agendas. Women’s rights, gender equality, and women’s health in particular, have grown increasingly ubiquitous in the world of global aid since the 1970s, a result of continuous feminist organizing efforts. The UN conferences on women in Mexico City in 1975, Copenhagen in 1980 and Nairobi in 1985 catalyzed the process through which women became a major topic in development (Bernal and Grewal 2014). NGOs were involved in this effort early on, initiated in large part by the decision made by the United Nations development Fund for Women (UNIFEM) in the late 1980s to use NGOs, rather than only UN agencies and national governments, to carry out their projects (Eisenstein 2009, 161). This long-term advocacy work resulted in several important

developments in the mid-1990s, including the 4th International Conference on Population and Development in Cairo in 1994 that put forth a comprehensive platform based on an expansive definition of sexual and reproductive rights. Subsequent UN conferences on women culminated in the 1996 conference in Beijing that ensconced gender analysis as something that “must be integrated into policy and programming in all areas” and established a detailed, multi-nodal agenda for “women’s empowerment” (Eisenstein 2009, 161). Today, issues and rhetoric related to gender equality and women’s empowerment, are ever-present in the world of international relief and development; they are established elements of development agendas issuing from the UN and central in the work of NGOs across the sector.²⁹

The ascendancy and acceptance of “women’s issues” in international agendas has not, however, constituted a wholesale embrace of feminist agendas. Following these achievements in the mid-1990s, conservative forces, evangelical American Christians in particular, have mounted campaigns to limit the scope of programs aimed at gender equality and sexual rights in particular. Such efforts gained traction in the early 2000s as advancements made in the 1994 and 1995 conferences in Cairo and Beijing respectively, which had put forth integrated and extensive agendas on women’s rights, were effectively rolled back (Glasier A et al. 2006). While the 1994 International Conference on Population and Development in Cairo recognized the importance of reproductive and sexual health and rights, defined inclusively, and called for universal access to sexual and reproductive health service by the year 2015, similar agendas were rejected by the UN Millennium Development Goals (MDG) in 2000. Conservative forces, namely

²⁹ Examples of these programs include those aimed at economic empowerment that cite women as critical to development, like the microcredit programs that received a frenzy of media and donor attention in the early 2000s, girls’ education initiatives, and issues of reproductive health. For more a summary of the rise of microcredit and its targeting of women in particular see Eisenstein (2009), p. 151-155.

“neoconservative Christian fundamentalists from the United States, Poland and elsewhere, Muslims of Saudi Arabia, Pakistan and other countries, and fundamentalist Hindus” insisted that the goals eliminate any “reference to the rights of women and the family” (Amin and Membrez 2006, 3). Their efforts effectively limited the scope of goal three, to “Promote Gender Equality and Empower Women,” to an assessment of empowerment measured only by “proportion of wage-earning women” and access to education (Amin and Membrez 2006, 3). This trend was indisputably abetted by the Bush administration’s management of USAID and its relationship to the UN, characterized by decisions like the one to withhold 3.4 million from the UNFPA (Barton 2005a, 103). Conservative backlash to advancements in women’s equality agendas was reflected in the non-profit sector as well. A 2007 report by Johanna Kerr from The Association for Women Rights in Development includes a survey in which two thirds of respondents, internationally operating women’s private non-profits, said that it had become harder since 2000 to raise funds for “issues related to women rights and gender equality” (Kerr 2007, 20). As the 2000s dawned, the advancement of women’s equality goals were being effectively constrained by apparently newly emboldened and activated conservative groups, American evangelicals prime among them.³⁰

³⁰ It should be noted here that just as socially conservative forces have limited the scope of feminist agendas in international health contexts, feminist organizing has also been limited by the neoliberal consensus among donors, lending organizations and the Northern political establishment. As Carol Barton writes, “while feminist economists and economic justice activists have worked hard to develop a feminist macro-economic analysis over the past 20 years addressing debt, structural adjustment, trade, neo-colonialism, and the current neo-liberal model from a feminist perspective, this is often still marginalized from what is considered a ‘feminist’ agenda” (Barton 2005b, 76). The concerns and agendas of Third World feminists have also been largely excluded (Eisenstein 2009, 164). Mexican activist and scholar Sylvia Marcos observed at the 1994 Cairo and 1995 Beijing UN conferences the way in which donors pushed out Third World feminist agendas, remarking specifically on the way in which birth rates and reproductive health, with their eugenic implications, while important, edged out other concerns, “as if no other issue of women’s health exists” (quoted in Waller and Marcos 2005, 148).

However, while certain elements of women's rights agendas, especially those related to reproductive health and the family, were under attack, "women's health" and "women's issues" as loosely defined general terms continued to gain traction in development agendas, the subject of funding both from bilateral and multilateral state donors but also from the general public. The institutionalization of women's empowerment agendas created a marketplace, as projects directed at these agendas eligible for funding from both state sources and private donation networks no doubt a result of a public increasingly supportive of women's causes and feminist issues. In this context, US-based relief and development INGOs have a financial interest in participating in projects that aimed at "gender equality" and such programs have proliferated in the past decades.

This is potentially reflected by the fact that even conservative-leaning, religious groups like World Vision have recently taken up the language of gender equality in ways they rejected in the early 2000s. World Vision, mirroring the ways in which it conformed to global trends in the relief and development sector to gain access to mainstream funding in the 1970s, now claims, since at least 2013, a "women's empowerment program."³¹ While it is framed as a birth spacing program, dubbed "Healthy Timing and Spacing of Pregnancy" (HTSP) and, of course, does not include abortion, World Vision now provides contraception, most likely a move to gain access to Obama-era USAID funds.³² They actively attempt to distance their programming from the

³¹ World Vision's "women's empowerment" program can found on its website. This page has been online, according to the Wayback Machine's archive, since 2013 (<https://www.worldvision.org/lp/empowerment>).

³² For example, they participated in a USAID funded project for an "Integrated Birth Spacing Project" that facilitated the distribution of birth control to Haiti, India and Senegal that operated from 2007 to 2012 and a similar program funded by the Bill and Melinda Gates Foundation that operated from 2013 to 2019 (World Vision 2018, 2–3). Backlash from the conservative anti-choice community evidences World's Vision's changing approach to women's health. Their participation in "family planning" or "birth spacing" programming has made them a target from

language of family planning and its association with abortion. Instead they emphasizing the benefits of preventing early pregnancy caused by early marriage, as a 2018 report described, “Available data indicates that the healthy timing and spacing of pregnancy (HTSP) through use of modern methods of family planning (FP) could prevent as many as one-third of maternal deaths by enabling women to delay their first pregnancy to at least age 18, space pregnancies by two to five years, protect women from unplanned pregnancy, prevent abortions, and limit childbearing to a mother’s healthiest years” (World Vision 2018, 1). This marks a notable contrast to the context of 2005 when World Vision had one of the highest revenues of all INGOs (income exceeding \$2 billion) and was a major recipient of USAID funds yet offered no women’s health program and provided neither abortion nor contraception (Kerr 2007, 13). While it remains unclear how substantive this shift is with respect to the acceptance of broader feminist platforms, it is clear that the language of women’s empowerment has become increasingly accepted even in conservative-leaning circles in recent years as they jockey for funding from donors that have in large part accepted reproductive health platforms.

However, while on one hand the increasing marketability of women-focused programs and the discursive malleability of “women’s health” lends itself to co-optation from forces who oppose a larger feminist platform, like Mercy Ships and Shannon Ethridge for example, the extent to which issues like obstetric fistula when framed in terms of racialized cultural pathology, have posed genuine sites of convergence for progressive feminists and evangelical conservatives also requires analysis and critique.

pro-life voices that consider them distributors of abortifacients and their attempted rebranding of family planning as birth space as a cover for their larger alliance with “pro-abortion forces” meaning funders like USAID (Michelle-Hanson 2013). See Michelle-Hanson’s article on anti-choice site, Live Action News.

The “Tragic” Narrative of Obstetric Fistula

While obstetric fistula has been understood and treated throughout the 20th century (and the first fistula hospital in Sub-Saharan Africa was established in 1975), it has only recently been singled out by the relief and development world and media outlets. Beginning in the early 2000s, discussion of obstetric fistula began to proliferate in the global health circles, the subject of extensive media coverage and increasing attention from the donor community (Winfrey 2005; Smith and Bucher 2007; Hamlin and Little 2001; Obstetric Fistula 2019). The UN Population Fund launched the Global Campaign to End Fistula in 2003 and in 2012 May 23rd was announced as International Day to End Obstetric Fistula. Fistula was featured in stories by media outlets like CNN, the subject of multiple articles in the New York Times—several of which were penned by Nicholas Kristof, the op ed author Carole Vance signals as a main writer of melodramatic journalistic exposés on sex trafficking—a featured 2005 segment on the Oprah Winfrey show and the topic of multiple documentaries including one, *Shout Gladi Gladi*, narrated by Meryl Streep, released in 2005 (A. Friedman and Kennedy 2015; Kristof 2018, 2016; Lafraniere 2005; Winsor 2013). A Google ngram search, which measures Google books data, charts a rather meteoric rise between 2000 and 2008.

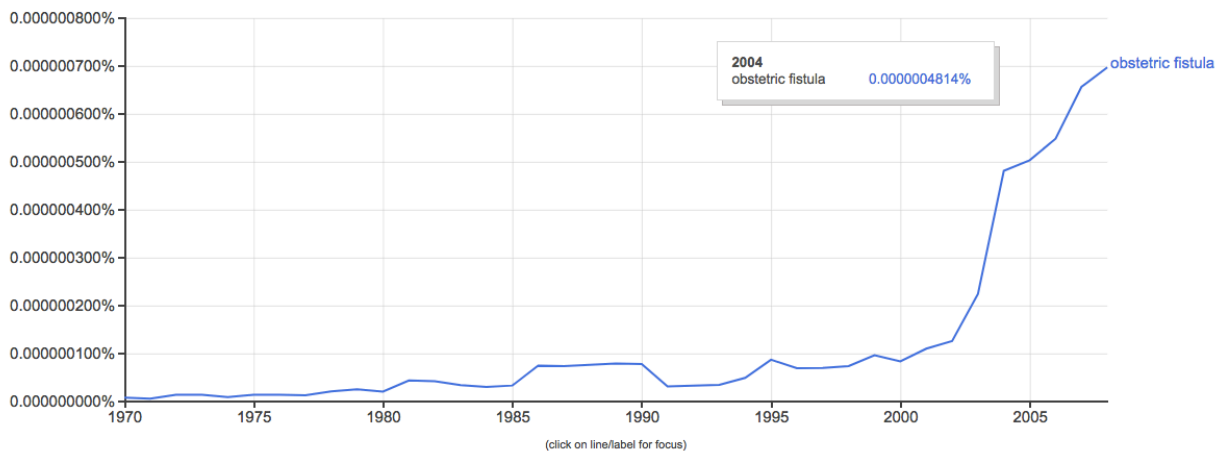


Figure 1: Ngram Viewer, Obstetric fistula 1970-2008. (Google Ngram Viewer 2019).

These widespread presentations of obstetric fistula by media and advocacy groups have, as anthropologists Allison Heller and Anita Hannig analyze in their 2017 article “Unsettling the fistula narrative: cultural pathology, biomedical redemption, and inequities of health access in Niger and Ethiopia” a particular and rather uniform character. Bespeaking the legacies of racist cultural pathologization of the African continent and its people, represented by the histories of medical missions and the colonial deployment of the “woman question,” these stylized narratives center on the figure of the tragic fistula sufferer, the victim of patriarchal culture, nearly always from Sub-Saharan Africa, and they also always turn on the purported total effectiveness of VVF surgery. Though it was the introduction of emergency obstetric intervention, namely c-section, that was responsible for the elimination of obstetric fistula in the developed world, media and donor coverage emphasize cultural factors and elide structural economic analysis, centering surgical repair over infrastructure building. The typical narrative is as follows:

Fistula sufferers are typically said to be young girls forced into ‘child’ marriages and precocious pregnancies. In the wake of an unattended, protracted home labour—which leads to fistula—these girls are thought to be rejected by their husbands, abandoned by their kin, and exiled from their communities. Owing to their incessant leaking and its conspicuous smell, they are allegedly demoted to the status of social pariahs and relegated to the outskirts of their communities—despised and deserted. Fistula sufferers reportedly find salvation in a life-changing surgery that restores their continence and enables their return to society. (Heller and Hannig 2017, 82)

These “highly stylized” tragic narratives reiterate and reify well-worn gendered, racist and sexualized logics that portray African family structures, and African men in particular, as violently patriarchal and traditional in overt ways. Such logics are apparent in the attribution of fistula to premature, assumedly culturally forced, child marriage, sexual intercourse and childbirth. Although obstetric fistula affects women of all ages who do not have access to proper obstetric care, Nicholas Kristof in the *New York Times*, for example, identifies fistula as

something primarily suffered by underdeveloped teenagers “whose pelvis[es are] not fully grown” (Kristof 2009). Husbands in particular, and communities generally, are portrayed the cruel and backward. As Mercy Ships details in a blog post, “Realizing that his wife would probably never have children, he decided to leave and take another wife because he still wanted children. He told Gisele, ‘With you, I am wasting my time.’” (Mercy Ships Provides Free Obstetric Fistula Surgeries in Africa” 2014). Even physical pain takes a backseat as, according to Mercy Ships, “nothing compared to the accompanying emotional burden of her husband’s rejection” (“Mercy Ships Provides Free Obstetric Fistula Surgeries in Africa” 2014). Treated as “social pariahs” by their communities, fistula sufferers are allegedly too ashamed to participate in daily life, representing a legacy of medical missionary portrayals of African women, too ignorant or superstitious to understand their illness, often described as attributing their affliction to evil spirits. Here, finally, enters the potent fistula surgery, an act of biomedical and spiritual salvation that Mercy Ships, for example, marks with a ceremony that celebrates these women’s “new life.” African women with fistula are portrayed as absolute victims, helpless, and ignorant, as – in Nicholas Kristof’s words – “perhaps the most wretched people on this planet” or, in his 2016 piece’s title, “The World’s Modern-Day Lepers: Women With Fistulas”(Kristof 2009, 2016). This horrific fate is put in contrast to all the good that the West offers, both culturally and bio-medically. Per CNN: “[Obstetric Fistula] is a condition practically unheard of in the United States and most Western countries. But in a culture where a woman's status and dignity is decided by her ability to provide a husband with multiple children, it can be a fate worse than death” (Winsor 2013).

As one might expect given the not so subtle racist economies at work, these narratives are premised on a series of at least exaggerated if not erroneous and misleading assumptions.

Through over two years of ethnographic research at fistula repair centers in Niger and Ethiopia, Hannig and Heller found that women with obstetric fistula did not in fact become social pariahs but rather had enduring, if also at times complicated, relationships with their families and communities (82). Furthermore, they found, the emphasis on surgery, in narratives which often feature a heroic (white) male fistula repair surgeon not unlike the medical missionary of the 19th century, is misplaced at best, as the effectiveness of surgery itself is exaggerated (e.g. Kristof 2016; Lafraniere 2005). While VVF surgery is presented as a total cure, Hannig and Heller note to the contrary that “A rare follow-up study conducted by the Bahir Dar fistula centre in Ethiopia found that 31% of those who had previously been discharged as ‘cured’ had developed residual urinary incontinence and that in another 9% the repair had broken down (Browning and Menber 2008).

These misrepresentations, misunderstandings and racist assumptions combine, as Heller and Hannig note, to divert analysis from the socioeconomic and political causes of fistula: “Framing a health condition like fistula as a cultural issue has had the unintended side effect of diverting attention away from both sustained health infrastructure reforms and the politico-economic systems within which these inequities emerged” (92). The question of intentionality aside, why, given the misunderstandings, falsehoods and counterproductive elements of stylized fistula narratives, does donor and media coverage fixate on this story? Hannig and Heller attribute it to its profit-making potential. Quoting one health researcher, they write, “‘It’s easier to get funding for fistula treatment than it is to raise money for more hospitals with maternity wards’” (91).

This reading is supported by Mercy Ships’ participation with obstetric fistula given its reliance on individual contributions and utilization of the most easily marketable health issues.

Its participation also bears out Hannig's and Heller's point regarding how these narratives function to "unintentionally" divert funds from infrastructure building programs that would actually address the root causes of fistula. With Mercy Ships' funding from USAID's ACQUIRE project, money was not only directed away from larger reproductive health agendas, but also, even within the already problematic Fistula Care Project, Mercy Ships' sole focus on VVF surgery potentially diverted funds from other more infrastructure-centered projects. In this respect and in others, Mercy Ships represents a rather potent version of the issues embedded in the stylized fistula narrative and is distinctive in a few further notable respects. In addition to its sole focus on the contested fistula VVF surgery, as compared with EngenderHealth, for example, its language is more stylized and less fact-based, as one would expect given the overall fundraising style, and it places significantly stronger emphasis on the "spiritual" salvation of fistula repair surgery.³³

³³ Prevention and infrastructure building become increasingly prominent in the language of the USAID funded fistula project, now called Fistula Care Plus (a name which indicates its more expansive programming) since the dissolution of its partnership with Mercy Ships. The description of fistula on its current website demonstrates the evolution of its presentation and movement toward: "Between 1 and 2 million women are currently in need of fistula repair. Fistula is a problem that can be prevented with family planning and access to timely and skilled maternity care. Our vision is that the next generation of girls will no longer need to be concerned about obstetric fistula by the time they begin to start their own families" ("Program Background – Fistula Care Plus" n.d.). While some of this language was reflected in the first iteration of Fistula Care Project, VVF surgery had a much larger place and it appears that their direct sponsorship of VVF surgery ended in 2013. While the archived website highlights surgeries the current website only list surgeries performed before 2013. Under survivor stories it states, "Between 2005 and September 2013, 33,402 fistula repair surgeries were supported with funding from USAID, over 23,000 of which were supported by Fistula Care." A move away from surgical solutions is positive, as is the more nuanced language. However, as examined here, fistula remains a problem in many ways outside the scope of the NGO. (see: fistulacareplus.org and fistulacare.org/stories-from-the-field/survivor-stories/).

Furthermore, obstetric fistula serves Mercy Ships in ways that differ somewhat from how it serves the sector broadly. VVF surgery allowed them access to federal funding for the first time and today, with federal funding streams no longer active, allows them to present a forward-facing, increasingly legitimating, women's health program. While in 2005 Mercy Ships put VVF surgery under "Childbirth Injuries" it is now the centerpiece of their "Woman's Health" program, the sole procedure other than "screenings," a change that indicates the increasing mainstreaming of "women's health" rhetoric in conservative circles following the early 2000s. In this sense, the organization benefits from the definitional ambiguity of "women's health" as a discursive field, able to access private and public fundraising without participating in reproductive and sexual health programs typically associated with women's health initiatives. This reflects an issue in global health broadly. As Marcia Inhorn examines, while the increasing focus on women's health since the 1970s has been positive in many ways, women's health has also been subject to "biomedical hegemony" with Western biomedical establishments often those in charge of defining what falls under the category of women's health and therefore women's health agendas (Inhorn 2006, 348). One result of this definitional hegemony has been what she refers to as "reproductive essentialism," as "women's health" initiatives since the mid-1970s overwhelmingly "focused on women as reproducers and as mothers to their children" (351). This is certainly the case for fistula repair as employed by Mercy Ships that, even beyond an emphasis on reproduction, focuses specifically on a view of motherhood to the exclusion of sexual health in ways that align with its conservative social values. Its introduction to the fistula topic, for example, begins: "The birth of a child should be a joyful experience" (Mercy Ships 2019).

This definitional malleability has opened the field of "women's health" to multiple and even competing definitions and therefore, as clear in this case, extensive co-optation. While

evangelicals and other social conservatives are quick to bemoan the degradation of traditional family structures within US borders, the result of feminism, access to supposedly promiscuity-encouraging birth control, abortion and so on, they are, apparently, equally quick to deride the “traditional” patriarchal cultural practices of African communities in which women are valued only as reproducers.³⁴ In the case of Mercy Ships, addressing obstetrics allowed them to make the highly hypocritical statement, especially when seen in light of Shannon Ethridge’s messaging on heterosexuality, now removed from their website: “In parts of the world where a woman’s worth lies in her ability to bear children and her usefulness as a wife, their husbands and families often abandon them to suffer alone” (Mercy Ships 2010).

However, potential cooptation aside of women’s health agendas aside, the ease with which fistula repair as cause fit into Mercy Ships’ existing fundraising structures, the tragic narratives in which they traffic, and their surgical emphasis is telling for the sector at large. Their presentation of fistula is simply one example of many and in many ways obstetric fistula offers a concrete example of the issues at large with racialized deployment of “women’s issues.”

Obstetric Fistula: Disguise and Site of Revenue-Generation

Obstetric fistula as a global health issue must, like many, be read in light of the socio-economic history and present of Sub-Saharan Africa. As Heller and Hannig write it is “deeply enmeshed in geopolitical priorities, structural adjustment policies, and legacies of colonization

³⁴ As Sara Farris and others have examined, nationalist anti-Muslim and anti-immigrant movements in the US and EU are increasingly taking up a gender equality lexicon to advance their political agendas (Farris 2017). As Farris notes, this is not a one sided co-optation for the achievement of their xenophobic goals but anti-Islamic rhetoric has proven to be a point of convergence for some feminists, neoliberals, and right-wing forces, with prominent feminists and even typically anti-nationalist neoliberals adopting anti-Islamic positions on the grounds of “women’s rights.”

and post-colonization, which have crippled local economies and public services in the global south” (91). In this sense obstetric fistula can serve as potent example for feminist critiques that take issue with “gender mainstreaming” in the international development world and the extent to which women’s agendas have aided and abetted neoliberal policy by, among other things, serving as a substitute for economic state-led development. While demonized by neoliberalism, state-led development, scholars note, was critical to the development of the world’s great industrial powers (Alvarez 1999, Marcos 2005, Fernandez-Kelly 2007, Bulbeck 2007). These critiques locate NGOs working on gender inequality in a larger system of neoliberal financing that has been to the detriment of women in the developing world. They point out that gender-focused NGOs have served as conduits through which funding was directed away from states, especially in Africa, and therefore are directly implicated in the stymieing of infrastructure development (Federici 2001; Eisenstein 2009, 135). Indeed, despite increasing ubiquity of gender terminology, conditions for women have in many places continued to worsen in the context of growing global economic inequality and the dismantling of states. Women are particularly disadvantaged, “the reduction or elimination of free education, health care, and free water becomes a particular burden on women” (Eisenstein 2009, 133; Barton 2004).

Obstetric fistula programs reflect this analysis directly as in order to substantively address and end obstetric fistula would require building obstetric health infrastructure, a process that requires a state involvement. In fact, the imposition of structural adjustment and the gutting of health care are direct culprits leading to far more cases of obstetric fistula. The associated introduction of “user fees” in Sub-Saharan African states, a program that requires a buy-in for the individual participant of state services, has been particularly detrimental to maternal and infant health, which correlate to fistula incidence. As Amdieme notes, “UNICEF’s 1993 figures

place maternal mortality rates in Ghana as high as 1,000 deaths to 100,000 births, one of the highest in Sub-Saharan Africa. In Zimbabwe, the maternal mortality rate rose from 90 per 100,000 live births to 168 per 100,000 in 1993 following the introduction of user fees” (Amadiume 2000, 28).

In other words, fistula is not only something the Mercy Ships, a hospital ship docking in different countries every month providing questionably effective surgeries, is incapable of adequately addressing. It is also most likely outside the purview of even more infrastructure-focused NGOs. While some funds from EngenderHealth and USAID have gone to infrastructure building, on a broader level the neoliberal rhetoric and logic supporting the development work of NGOs is directly related to the gutting of state-led development and medical infrastructure that contributes to fistula incidence (Eisenstein 2009, 145-6).³⁵

In light of these analyses, the failure of fistula programs to properly address the underlying, structural conditions that cause this health issues is arguably more than what Hannig and Heller term an “unintentional” misallocation of resources (96). To some critics, the utilization of women’s rights rhetoric and proclamations of the success of feminist interventions has provided international agencies, monetary bodies and the relief and development world broadly a “disguise for the reality” of the effects of neoliberal austerity and debt restructuring packages in the global south (Eisenstein 2009, 137; Barton 2004, 173). The very invocation of gender equality and woman’s rights serves as a moral cover for the system of financing and

³⁵ It should be noted, that fistula also demonstrates the extent to which feminist organizing in international health contexts have been constrained by the neoliberal market and imperative. As Carol Barton writes, “while feminist economists and economic justice activists have worked hard to develop a feminist macro-economic analysis over the past 20 years addressing debt, structural adjustment, trade, neo-colonialism, and the current neo-liberal model from a feminist perspective, this is often still marginalized from what is considered a 'feminist' agenda” (Barton 2005b, 76).

global wealth maldistribution that makes it near impossible to address the root cause of issues like fistula. This extends not only to women's issues but, as Samuel Moyn argues convincingly, to human rights discourse broadly which has especially since the 1970s aligned itself with neoliberal economic agendas (Chossudovsky 2003; Moyn 2018a). In focusing narrowly on civil and political liberties, mainstream international human rights discourse, which includes women's rights, has ignored and sidelined essential analysis of and action on massive economic inequality. Marginalizing and silencing economic analyses both overlooks the extent to which violations of rights increase and worsen under conditions of economic inequity and critically, as is becoming increasingly urgent, highly unequal economic conditions gives rise to far right, nationalist and authoritarian movements that are today the biggest threat to the rights of minorities, women and other vulnerable populations (Moyn 2018b). A narrow focus on these cultural and gender issues and the declared success in these fields has in a sense served as "Trojan horse" for economic and political policies that have been to the detriment of women and other vulnerable populations (Eisenstein 2009; Chossudovsky 2003). In this respect, contemporary invocations of women's rights and issues in the mainstream relief and development world function very much like colonial discourse related to "the woman question." In the same way that humanitarian appeals, espoused by the medical mission and colonial programs aimed at "saving women," served as a convincing rationale for colonial interventions and successfully diverted attention from larger structural economic and political concerns, today issues like fistula, female genital cutting and sex trafficking give moral cover to the extension of neoliberal economic policy and, likewise, divert attention from structural effects of these policies.

I would add, however, given the exposure of the development world to the market and the changes that occurred in the sector in the 1980s onward, that mainstream discourse on

women's rights and health in these circles also can be read as a site of essential revenue generation, the centerpiece of many organizations' fundraising strategies. It seems clear that the taking up of cultural issues related to women continues to be highly marketable, an essential way in which NGOs of all types solicit private donations. As Heller and Hannig note, it is easier to fundraise on the image of the victimized fistula sufferer, no matter the content of the project, than it is to fundraise to build a hospital. It is unlikely that Mercy Ships, based on its financial structure and approach, would not continue to advertise its VVF program if it were not a draw for the private donor as USAID funding has long dried up. In this sense, obstetric fistula as a *cause du jour* in global health can be read in many contexts. It is related to the rise in women's health concerns related to feminist advocacy, a useful cover for neoliberal action, a cultural diversion from the effects of economic policies, and, as a reiteration of a long-standing racialized, sexualized and gendered dynamics endemic to the project of "saving women," a site of revenue-generation for NGOs seeking successful fundraising strategies. While the activation of the sentiment to rescue "other women" is long-standing and continues to underwrite rationalizations for contemporary Western military interventions, its monetization through its utilization in NGO fundraising is somewhat unique to the neoliberal marketplace of contemporary relief and development, global health and humanitarianism generally in which modern NGOs operate.

Obstetric fistula: Negative Mirror and Sleight of Hand

In light of this analysis it seems appropriate to question why it is that obstetric fistula, continuing a tradition that Vance identifies with respect to gendered issues like "sex-trafficking," offers "capacious home for reactionary and progressive impulses" (Vance 2011, 136). In

contemporary contexts this convergence, as Vance remarks, and as clear with obstetric fistula, has been especially pronounced in the US between feminist and evangelical conservatives. Obstetric fistula presents an interesting example of this union as it is related to reproductive health but not to contraception or sex as such. It seems that those that would normally be on opposite sides of conversations regarding reproduction or the role of women in the family are able to come together when, as is the case with fistula, gendered issues staked in race are located in demonized cultural contexts outside of the “West.” While bad faith cooptation by parties hostile to a broader feminist agendas is one element at work in gender mainstreaming it does not account for the ways in which certain causes and issues related generally to gender have proved to be points of convergence for both bona fide women’s rights development organizations and conservative groups, historically and today. Fistula repair narratives, the way it is presented as an issue by organizations like Mercy Ships and EngenderHealth alike, points to the extent to which racialization, via gender and sexuality, is the uniting factor for these often opposed groups.

I would like to end by problematizing the way in which these narratives continue to provide points of convergence between progressive feminists and social conservatives and offer some tentative readings of obstetric fistula based in theories put forward by Alia Al-Saji and Carole Vance in particular. Here, I would like to return to Shannon Ethridge’s claim that initiated this investigation but with it, similar statements about “African” fistula sufferers from diverse media sources and donor organizations across the spectrum. Taking up Al-Saji’s question with respect to the image of the veiled women, I wonder about “the hold and force” of the representation of fistula “on the Western imaginary” (68). How does the racialized image of the fistula sufferer, tragic, maritally rejected and sexually unconfident, act on the Western imagination, the donor, media consumer, Oprah watcher, *New York Times* and Shannon Ethridge

reader alike? Why is it that donors and media are drawn to these images of the fistula sufferer and what is at stake in marking African women as the “least sexually confident” and the “most wretched” people on earth?

Al-Saji offers a compelling analytic lens. Turning Fanon’s analysis in *Black Skin, White Masks* to figure of the “veiled Muslim woman” Al-Saji looks closely questions of gender. According to Fanon the collective guilt of white society is borne out by the racialized “scapegoat.” He writes, “Now the scapegoat for white society—which is based on myths of progress, civilization, liberalism, education, enlightenment, refinement—will be precisely the force that opposes the expansion and the triumph of these myths. This brutal opposing force is supplied by the Negro” (Fanon 2008 [1953] 150). Al-Saji suggests that “it is the undesirable alterity in woman that is projected on the ‘veiled woman,’” the image of the veiled women providing the opposing force that allows the so-called “Western woman” to constitute an unified ideal (Al-Saji 2009, 75). In this respect, the discourse on the oppression of Muslim women, she argues, effectively locates gender oppression as the far- off property of the “East,” serving a dual purpose. She writes, “the moral justification that this discourse seeks to impart is not limited to the colonialist or neo-colonialist project abroad but extends to a justification of patriarchal constructions of gender in the home society” (69).

Carole Vance makes a related argument regarding sex trafficking as an issue that, like obstetric fistula, constitutes a *cause du jour* in international global health. Like Al-Saji, she understands conversations about and related to gender that position the patriarchal oppression in a removed context—whether it be the dangerous sexual underworld of prostitution in the 19th-century debates or the impoverished geographies of the global south that characterize contemporary depictions of sex-trafficking—as displaced conversations about the home

environment. She argues, “Critiques of heterosexual intimacy, institutions, and economies are redirected to the exceptional and the sexual in contemporary campaigns against trafficking” (Vance 2011, 135). Nineteenth-century crusades against sex trafficking, she points out, occurred in a historical moment when women lacked rights of legal personhood, the right to vote, or own property. In this context, “married women’s ability to expose and challenge male sexual privilege in marriage” was constrained and sex trafficking crusades served a place where challenges to male sexual privilege in marriage could be “perhaps more safely displaced” (Vance 2011, 137). Today, conversations about heterosexuality, gender inequity and sexual violence, are similarly redirected at those who are considered “Other,” for contemporary portrayals of sex-trafficking victims almost always focus on women and girls in the global south.

In this context, it is worth asking what is made coherent, what is justified about the patriarchy at home and what conversations are displaced by fistula repair as depicted by “Western” media and donor organizations. To return to Shannon Ethridge’s claim, the imagined figure of the sexually disempowered African woman with fistula arguably serves to make her pseudo-female empowerment message appear coherent. Similar to the dynamics identified by Al-Saji, for Ethridge the figure of African obstetric fistula sufferer positively reflects her vision of the sexually enlightened, sexually confident, sex-loving white Christian wife and makes her in many ways retrograde message fit within frameworks of contemporary liberalism. In the context of the patriarchal gender dynamics that define American evangelicalism, the statement that African women are the least sexually confident, the most victimized, can also be read as a site where anxieties and conversations about sexual disempowerment can be projected at a safe distance.

With respect to fistula rhetoric employed more broadly in places like the *New York Times* and by EngenderHealth, imagining the far-off culture where, as CNN put it, “a woman's status and dignity is decided by her ability to provide a husband with multiple children” can also be read critically (Winsor 2013). Turning inward, to put forth just a few potential examples, one could relate this statement to the continuing assault on reproductive rights in the United States that makes such a characterization seem too close for comfort. Furthermore, declarations that women with fistula are some of the most abused and ill people on the planet, invites a consideration, given its relation to obstetric care, to the appalling state of maternal and infant health for African American women in the United States. After all, while obstetric fistula has been eradicated, maternal and infant death rates among African American women are not so unlike those in Sub-Saharan Africa. A report from the UN Committee on the Elimination of Racial Discrimination states “in some areas of Mississippi, for example, the rate of maternal death for women of color exceeds that of Sub-Saharan Africa, while the number of White women who die in childbirth is too insignificant to report” (McDonald 2016). The projected cruelty of African husbands who reject their wives might be put in conversation with the extent to which racial bias among health care providers and systemic racism is violently affecting African American women and their children. These are just some tentative examples but investigating how and why victimized women in racialized contexts abroad continue to figure prominently in discourse of Western health and gender equity organizations and the media, should be on the agenda for future research.

CONCLUSION

This thesis has established the context for Shannon Ethridge's arresting statement on women with obstetric fistula, Mercy Ships' fistula repair program and the ways in which causes like obstetric fistula tap into a long, racialized history that continues to operate across the spectrum of NGOs. I have put forth several readings of the odd alliance between Mercy Ships and EngenderHealth, two entities that one would expect to be on opposite sides of a reproductive health issue. I have made the case that obstetric fistula as deployed by Mercy Ships, EngenderHealth and the sector at large reveals the ways in which longstanding imperatives to save "Other" women are reiterated in contemporary neoliberal contexts. As they once distracted and diverted attention from the effects of colonial rule project they now distract from the effects of neoliberal economic policies enacted on the global south. With Mercy Ships as my central case, I have demonstrated the ways in which melodramatic narratives rooted in the "protection" and "rescue" of women circulate in the contemporary world as sites of revenue generation. As organizations compete for state funding and the donation of the individual donor to fund their programming and administration, long-utilized stories regarding the rescue of abused women are leveraged as a successful fundraising strategy.

I understand this critique as equally applicable to organizations and stakeholders with what could be described as more sincere feminist leanings. While emphasizing VVF surgery and the figure of the African fistula sufferer can be read as an effective fundraising strategy this does not excuse participation in a discourse that actively reproduces and perpetuates harmful, racist images of African women and men. The these fundraising strategies may generate revenue that fund the best version of fistula programming is not especially comforting, especially in light of the structural inability of fistula programs to properly address the conditions that cause this

health issue and the suspect efficacy of VVF surgery. What is being done with the revenue generated by tragic fistula narratives, where it is going and how effectively it is being distributed, is a critical question that requires further research.

In this sense, obstetric fistula is but one manifestation of the larger issues at work in the world of international relief and development. These issues will likely persist so long as the majority of development aid allocated for reproductive and maternal health goes through Northern NGOs in their current iteration. It is hard to imagine an alternative if NGOs continue to rely on the solicitation of donations from a public moved by racist and sexist tropes and the support of governments, donors and international monetary bodies with vested interests in the extension of economic and political policies that contribute directly to worsening conditions for the very beneficiaries international NGOs claim to be serving.

Finally, I hope to have also made the case, by returning to Shannon Ethridge's troubling statement about African women, and with it those from the *New York Times* and CNN, that the enduring tendency of progressive feminist-leaning organizations and discourse broadly to engage in racialized forms of sexism and sexualized forms of racism should be critically interrogated with respect to humanitarian projects especially. As feminist scholars we should ask, as Al-Saji and Vance do, not only what Ethridge's statement of the sexually least confident women does for her project but also why widespread depictions of monolithically rendered African women continue to proliferate in progressive feminist circles, captivating Western feminist audiences who may be better served by examining at the conditions of patriarchy "at home."

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