Development Imaginaries:
Gender and Comparative Aid Chains in Cambodia

Mary-Collier Wilks
Baton Rouge, LA

MA, University of Virginia, 2017
BA, Eckerd College, 2012

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Committee Members:
Dr. Jennifer Bair (chair)
Dr. Simone Polillo
Dr. Adam Slez
Dr. Sarah Corse
Dr. Sylvia Tidey (anthropology)

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Chapter One
Introduction

Around seven in the morning in July 2011, while interning at a local nongovernmental organization (NGO) in Cambodia, I travel by motorbike with my Khmer co-worker, Lakena. We are going to the NGO's provincial office in Kandal, just outside Phnom Penh. We ride past the rapidly developing cityscape of the capital, bustling with people beginning their day, until the scenery changes to wooden houses and rice fields. As we arrive at the provincial office, the staff are hurrying to set up for a training, putting out chairs, hanging posters, and printing fliers. The local NGO where I am an intern works with female and child survivors of gender-based violence, and women in poverty. Lakena informs me they will be giving survivors a training on entrepreneurship and small business ownership this morning.

As an intern, I am not yet aware of the ubiquity of such trainings on the international development scene. I inquire why the staff selected that topic. Lakena laughs a little bit and explains, "it is *a way* of helping the women." She tells me entrepreneurship can help survivors to gain money and independence. However, pointing at me, an American, she asserts– "it is also *your* culture." At the time, I did not fully understand her meaning. As I spent more time at the NGO, it dawned on me. The above training was funded by the local NGO's U.S.-based donor. The other trainings and services they provided looked a bit different. For instance, workshops funded by the organization's European donor promoted women's grassroots advocacy through community groups while its South Korean donor supported maternal literacy.

NGOs are important actors in the development field that provide information and services aiming to advance or 'develop' nations in the global South. They often work in 'aid chains' in which programs, such as health or education activities, are funded by donors in the global North. The blueprints or ideas for such programs travel from donors and international NGO (INGO) headquarters, to INGO country offices in recipient nations, and then to implementing partners, like the local NGO above (Watkins, Swidler, & Hannan 2012). In this process, international and local NGO workers in recipient nations, like Lakena, enact a "broker" role, negotiating between the priorities of international donors and local stakeholders (Fechter 2012; Swidler and Watkins 2017). However, dominant studies of NGOs largely focus on the global similarities between

donors and their programs. Investigating the differences pointed out by Lakena above, this research asks – do donors and INGOs from different nations define development differently? And, if so, what does that mean for practitioners, stakeholders, and beneficiaries in recipient nations?

To answer these questions, I conducted a multi-sited, comparative ethnography investigating the work of two INGOs, their donors, and their implementing partner organizations in Cambodia. The INGOs, hailing from Japan and the U.S. respectively, ostensibly work towards the same development objective: improving women's health. However, each INGO implements very different programs in Cambodia. For instance, the Japanese INGO in my study, which I call Health Services Asia (HSA), focuses on strengthening government-provided maternal and newborn health services. Contrastingly, the U.S. organization, Global Family Aid (GFA) promotes a diverse maternal and reproductive healthcare sector, including private providers and civil society organizations. This dissertation analyzes the causes and consequences of aid chain variation for programming, practitioners, and beneficiaries.

In this chapter, I provide an overview of the case and my methods, and introduce the main argument of the manuscript. However, before doing so, I examine what existing research on INGOs and international development can tell us about national variation in INGO activities.

Homogeneity in Development: Global Diffusion and its Limits

Research on NGOs exhibits a tension that is common in studies of globalization and international organizations – global processes produce both homogenization and heterogeneity (Guillen 2001). Below, I analyze the insights from four prominent perspectives on INGOs and international development. These four perspectives fundamentally understand INGOs as key vehicles for constructing and dispersing international norms, demonstrating forces of homogenization. After introducing these perspectives, I will turn to studies that examine the other side, documenting forces that create heterogeneity in NGO development practices.

First, world polity theory was one of the first sociological approaches to focus on INGOs and remains a dominant lens for studying development organizations. It investigates an important question – why do global development norms and programs look so similar, at least in their formal discourse, around the world? World polity research illustrates important processes in the construction and homogenization of global development norms and organizational practices.

Emerging out of new institutionalism, world polity scholars contend that after WWII, the structuration of the world polity took place (Meyer et al., 1997; Meyer 2010).

In the world polity, INGOs work alongside states, intergovernmental organizations, and transnational corporations in an organizational field. Here, "world culture" models, including global policies and organizational practices are developed. World culture includes dominant global norms such as rationalization, individualism, education, rights, or the nation-state form (Meyer, 2010; Meyer & Bromley, 2013). For instance, Kentikelenis & Seabrooke (2017) examine global script writing by analyzing how a taxation policy gains consensus at the International Monetary Fund (IMF). They document negotiations between the state representatives on the IMF board with political interests and professional experts on the IMF's staff in the writing and enacting of a global script.

After norms are constructed, states and international organizations feel pressure to, at least formally, adopt world culture norms to gain legitimation in the international field, which results in isomorphism among global organizations (Boli & Thomas 1999; Tsutsui 2018). Specifically, world society engagement, including participation in international conferences, networking with other international organizations, and treaties on donor adoption of common aid approaches, has a strong positive impact on the growing similarity of development assistance policies across Western foreign aid donors. For instance, analysis of the foreign aid policies of OECD nations illustrates that all Western bilateral agencies enacted similar gender and development policies by the early 2000s (Swiss 2018). Foreign donors will often pursue similar policies, even when they do not necessarily increase aid effectiveness (Brown and Swiss 2013).

INGOs enact and promote world culture norms in numerous sectors, such as economics, education, environmentalism, and health (Boli and Thomas 1999; Chabbott 1999; Frank, Longhofer, & Schofer 2007). Specifically, INGOs, alongside other world society organizations, played an essential role in the diffusion of global norms combating violence against women, pressuring states to enact policies and changing public opinion around the world (Htun and Weldon 2012; Pierotti 2013). Thus, world polity scholarship documents the power of dominant global scripts as well as the processes through which global scripts are constructed and diffused. However, it cannot fully explain the degree of *variation* in development activities and organizational models found in this study.

In the second perspective, scholars of Transnational Advocacy Networks (TANs) are similarly interested in the construction of global agendas and their dispersal. Yet, they use a social movement framework to investigate INGOs, showing how INGOs frame advocacy agendas, share policies across national contexts, and identify issues ignored by states and international institutions. Organizations in these networks leverage the international community to pressure states, corporations, and supranational institutions to enact their policy agendas (della Porta and Tarrow 2004; Keck and Sikkink 1998). When pressuring states, INGOs often support local NGOs and domestic activists promoting similar issues. Numerous international advocacy groups including environmental groups, women's rights, human rights, and labor rights use TANs to pursue their objectives (Ferree and Tripp 2006; Keck and Sikkink 1998; Moghadam 2005).

TANs scholars contend that transnational networks provide a crucial space for collective action against the inequalities produced by global capitalism for global civil society organizations (Moghadam 2005; Smith 2010). However, while TANs enable organizations to communicate and mobilize across space, access to these networks is uneven. Participation in TANs provide important opportunities and resources for outward-oriented or better-connected groups, while organizations with stronger local grassroots ties may be left out in the cold (Barnes 2007; Thayer 2010). Nevertheless, while TANs represent a different theoretical perspective on diffusion than the one centered by world society theory, this approach shares an emphasis on convergence, as INGOs participating in such networks define problems and organize their efforts around shared issues and common agendas (Keck & Sikkink 1998).

Third, there is a critical literature that challenges the assumption that INGOs and NGOs are agents of global civil society, separate from the state and market (Bernal & Grewal 2014; Goldman 2005; Rankin 2001). INGOs and other international development organizations participate in the promotion of global neoliberalism. In this perspective, the World Bank, the IMF, and multilateral organizations, like the UN, construct development discourse as part of the project of Western modernity. Often, ideologically driven recommendations and policies are made to developing nations, even if they might prove detrimental to social development, such as privatization, decentralization, and cost recovery fees in the health sector (Ugalde and Jackson 1995). The dominance of this global discourse produces a hegemonic agenda that makes

constructing development programs outside of the neoliberal framework very difficult (Bedford 2009; Goldman 2005).

Due to the proliferation of neoliberal policies over the past several decades, states cut back welfare spending around the world, and international and domestic NGOs sprung up to fill this gap in services (Neumann 2013). In remote areas of some developing nations, NGOs have even supplanted local governments as health providers (Janes and Corbett 2009). INGOs also gain funding from states, multilateral organizations, and companies endorsing neoliberal policies and ideologies (Banks, Hulme, Edwards 2014; Bernal & Grewal 2014; Wallace 2009). This has two important consequences. First, the need to gain funding pushes INGOs and local NGOs to enact an "audit culture" and place a high priority placed on professionalization. Consequently, NGOs often hire relatively privileged and highly educated employees who can draft budgets or write English language reports, instead of members of their grassroots constituencies (Alavarez 2009; Markowitz & Tice 2002; Roth 2012).

Second, neoliberal ideology may push NGO programs to propose individualized solutions, instead of addressing larger structural issues that underlie poverty (Bebbington 2005). In order to gain funding, INGOs construct programs to produce measurable outcomes that create entrepreneurial and self-reliant subjects (Hemment 2014; Rankin 2001; Sharma 2008). This third perspective takes a radically different outlook on the content of the development norms that INGOs are promoting. Nevertheless, it still assumes development norms and programming implemented around the world look relatively similar unless and until they are resisted and modified in recipient contexts.

Finally, an emergent body of scholarship complicates our understanding of isomorphic dynamics within global civil society by examining INGOs in a transnational Bourdieusian field or "a social space of relations or social configuration defined by struggle over capitals" (Go & Krause 2016: 8). In her study of humanitarian INGOs, Monika Krause (2014) argues that it is not just the vague norm of 'saving lives' that constructs this field, but rather the common effort to articulate a particular vision of what it means to provide relief. As the operative field level logic, this pursuit of the "good project" is manifest in the ways that INGOs construct, implement, and market their services to donors. Where scholars of World Polity or TANs see a transnational social space emerging from the diffusion of scripts and practices, the Bourdieusian perspective examines a shared but bounded logic of practice that constitutes a particular field.

Moreover, rather than convergence, a Bourdieusian field is rife with contestation as actors jostle to situate themselves vis-à-vis each other (Christin 2016). The global humanitarian field studied by Krause is structured by two dominant, but conflicting models of humanitarianism. The International Red Cross, which is the oldest humanitarian INGO, is seen as closest to state actors, and advocates for neutrality in providing aid to those in need, even in nations committing human rights violations. In contrast, Medicine Sans Frontières (MSF) is considered closer to a social movement pole within the field. MSF contends that humanitarian aid organizations must speak out against states committing atrocities. These two dominant actors create space for different positionings within the field of humanitarianism, resulting in variation in INGO rhetoric and practice. This perspective not only points to the importance of attending to the relational and contested processes through which organizations construct the space of development programming, but more broadly, when compared with perspectives that center diffusion, it permits a more dynamic and open conceptualization of field-level change (Go & Krause 2016). Yet, despite the nuance of this perspective, it still emphasizes dominant development rhetoric and practice in a *global* field.

In short, while the literatures described above each explain INGOs in terms of global processes---whether global norms (world polity), global movements (TANs), a global politico-economic regime (neoliberalism), or the logic of a global Bourdieusian field, they may overstate the degree of commonality among INGOs. Assuming *a priori* that an overarching logic is structuring the INGO field may cause us to neglect the degree of diversity actually observed in INGO practices. How do scholars of INGOs and international development understand variation in how global norms and practices are implemented in developing nations? To answer this question, I turn to studies of decoupling and adaptation.

Heterogeneity in Development: Decoupling & Adaptation

If the above diffusion frameworks center homogenizing forces, the scholarships I discuss in this section focus on heterogeneity, documenting how global scripts are modified as they are enacted in diverse recipient contexts. Many global norms and goals are abstract and general, making it difficult for organizations to implement these mandates (Moretti & Pestre 2015; Watkins, Swidler, Hannan 2012). Despite isomorphism in the rhetoric of global scripts, scripts are often modified or taken up in locally specific forms as they travel to different country

contexts (Chorev 2012). It is in this process that the broker role of INGO and local NGO workers in recipient contexts becomes important. NGO staff learn the rhetoric and skills required by donors and transnational organizations to gain access to the resources, and then, translate global norms and donor programs to be successful in their local environment (Swidler and Watkins 2017).

The world polity literature recognizes this adaptation process, describing it as de-coupling or the idea that while international organizations may adopt world culture policies formally (i.e. signing on to an international treaty), in practice, their activities may differ. Many factors may lead to the decoupling of policies and organizational practices, such as the relevance of the policy to local context, technical or financial capacity of organizations to follow through, and an organization's level of integration into the world polity (Boyle, Songora, & Foss 2001; Watkins, Swidler, Hannan 2012). First, purposeful decoupling may take place due to the interests and strategies of actors in international organizations. Second, contestation between actors can cause international organizations to deviate from global norms (Babb 2003; Moretti & Pestre 2015; Watkins, Swidler, Hannan 2012). Third, in the face of vague goals, organizational 'slippage' is likely, which means powerful external actors, available organizational models, and internal professionals may influence international organizations' policies and practices (Babb 2007).

Finally, often those most likely to take up global models, such as developing nations, are least able or willing to carry them out (Meyer 2010). Hafner-Burton and Tsutsui (2005) find that while the pressure of world society may be able to get states to adopt human rights policies, developing states frequently do not implement them. Nevertheless, their formal adoption provides domestic civil society actors with a kind of discursive leverage, as they can use the state's formal commitment to pressure it to implement the pledged policies. Thus, decoupling takes place in numerous ways, creating heterogeneity in INGO programming and practices globally.

Studies drawing on the TANs perspective also demonstrate the numerous ways that transnational agendas are promoted, adapted, or rejected in local contexts (Noonan 2002; Rinaldo 2013; Thayer 2010). Encountering global norms can help INGO staff to create new forms of solidarity, new agendas for mobilization, and shape the self-understandings of INGO and NGO staff (Davis 2007). For example, in Brazil, women working in a rural NGO

encountered the *Our Bodies Ourselves* movement that started in Boston. Rejecting the prominence of individual sexual pleasure in the text, their interpretation of the movement instead emphasized coalition building and the demand for reproductive rights and women's health services (Thayer 2010).

Finally, NGO workers also respond creatively to the constraints imposed by international donors and neoliberal ideals, constructing new forms of political agency in their local contexts (Bernal & Grewal 2014; Sharma 2008). For instance, in Israel, workers in a feminist microfinance institution modified neoliberal concepts, employing the term 'forced entrepreneur.' While the term still centers individual responsibility for earning an income, it acknowledges that entry into entrepreneurship is 'forced' due to a market system that does not afford women many other options. As such, it facilitates microfinance activities, while maintaining a critique of neoliberal politics (Kemp and Berkovitch 2019).

The above research illustrates the variety of ways NGO practitioners translate, modify, and resist global development models, reconstructing programs to fit recipient contexts. This project builds on these insights, examining the broker role that NGO practitioners play in translating development programming and practices. However, the above studies continue to assume that the content of global norms and programs practitioners encounter are largely similar and, then, modified in distinctive recipient contexts. Yet, I argue global development norms do not travel immediately from the international stage to be contested in recipient contexts; instead, the process of translation begins in the global North, reflecting variation among INGOs by nation of origin.

National Variation and INGOs

INGO practitioners may be embedded in a global field, but INGO headquarters exist in specific donor country contexts. It is a key insight of the above literature on adaptation that the way development practitioners in recipient nations interpret and modify development programs is affected by their national context. The concepts through which NGO practitioners understand the world are shaped by the social reality in which they live, including national norms, institutions, and practices (Davis 2007; Djelic 2008). I argue that practitioners in INGO headquarter organizations also translate global norms into distinctive programs and practices before they ever travel to recipient country contexts.

Recently, a handful of scholars have started to document national variation in development programs and practices. For instance, in his study of foreign aid donors, Liam Swiss (2018) emphasizes the increasing similarity of development assistance globally. But, he also argues that the influence of world society norms is mediated by national processes like public support for development, the structure of the aid agency (centralized, in which the majority of decision-making takes place in bilateral agency headquarters vs. decentralized, in which the majority of decision-making takes place in in-country offices), the degree of domestic civil society involvement in development, and legislative institutions all impact the development assistance provided by a nation.

Relatedly, there is also a newer literature on INGOs that draws inspiration from the Varieties of Capitalism (VoC) perspective to analyze national variation in donor country contexts. VoC argues that while there are some global pressures towards convergence, nations also display persistent and prominent institutional differences in their political economies (Hall & Soskice 2001). Scholarship that examines variation in national political economic institutions and how this impacts development provides a useful direction for two reasons.

First, it points to how the political economic context of "home countries" may affect the way INGOs operate abroad. While VoC research has focused primarily on economic actors and institutions such as multinational corporations, a number of scholars have extended the framework to consider development and international organizing. These are studies of "varieties of activism"—that is, the ways in which different national institutions and political cultures in home countries encourage distinct organizational strategies and identities among activist groups and international development organizations (e.g., Bair & Palpacuer 2012; Dietrich 2016; Schurman & Munro 2009; Stroup 2012). The political economy of particular nations deeply shapes INGO grant-making practices and programming—for example, whether development is seen as a process driven primarily by the market versus the state (Dietrich 2016). Sarah Stroup (2012) compares British, American, and French INGOs in their home country context. She finds INGOs are deeply influenced by national political context, regulatory framework, availability of resources, and social networks. This research has provided important insights into the ways in which INGO strategies and practices reflect the institutional configurations and political economic characteristics prevailing in their home countries.

However, the second important process the VoC literature demonstrates is the need to be attentive to how the institutional characteristics of the recipient countries shape the operation of INGOs abroad. Institutional differences in political economies shape organizational behavior. For example, multinational corporations often reflect the particular institutional characteristics of their home countries in their operations abroad, as when a country's relationship with labor unions at home affects the influence that unions have on it in host country contexts (Helfen, Schubler, and Stevis 2016). However, to be effective, multinationals also need to adapt their operations abroad. This process can result in hybridization or "institutional dualism," with national and local level forces interacting to create new organizational strategies (Morgan and Kristensen 2006).

While the varieties of activism research described above illustrates the existence of important national differences within INGO home country contexts, it does not explain how these are transmitted globally or in what ways national differences in development practices are hybridized abroad. Research is needed to specify the processes through which these national differences impact program construction and implementation on the ground. In particular, we need to better understand why national variation in programs and practices exists and how it travels to recipient nations, articulating in new political and cultural contexts.

INGOs in Aid Chains

I contend that answering these questions requires an analysis of the 'aid chains' through which development programs are delivered, and within which INGOs are typically embedded (Watkins, Swidler, and Hannan 2012). A typical aid chain begins with donor organizations, which may be corporations or international foundations, but are often bilateral agencies, e.g., USAID. Next in the aid chain are the INGOs these donors fund, which often maintain headquarter organizations in at least one developed nation and country offices in recipient nations. INGOs in turn frequently implement development projects via support provided to smaller local NGOs or receiving country government organizations. At least in part, aid chain dynamics are shaped by donor priorities and agendas, since most INGOs and local NGOs write grants appealing to specific donor priorities to fund their work. Organizations are required to represent their beneficiaries' needs to the organization above them at each level of the aid chain in order to gain funds (Bebbington 2005). By focusing on the concrete inter-organizational

relationships through which INGOs work, studying how programs and practices are shaped by the aid chain advances our knowledge of how national variation in development ideas and activities is produced in donor contexts as well as recipient nations.

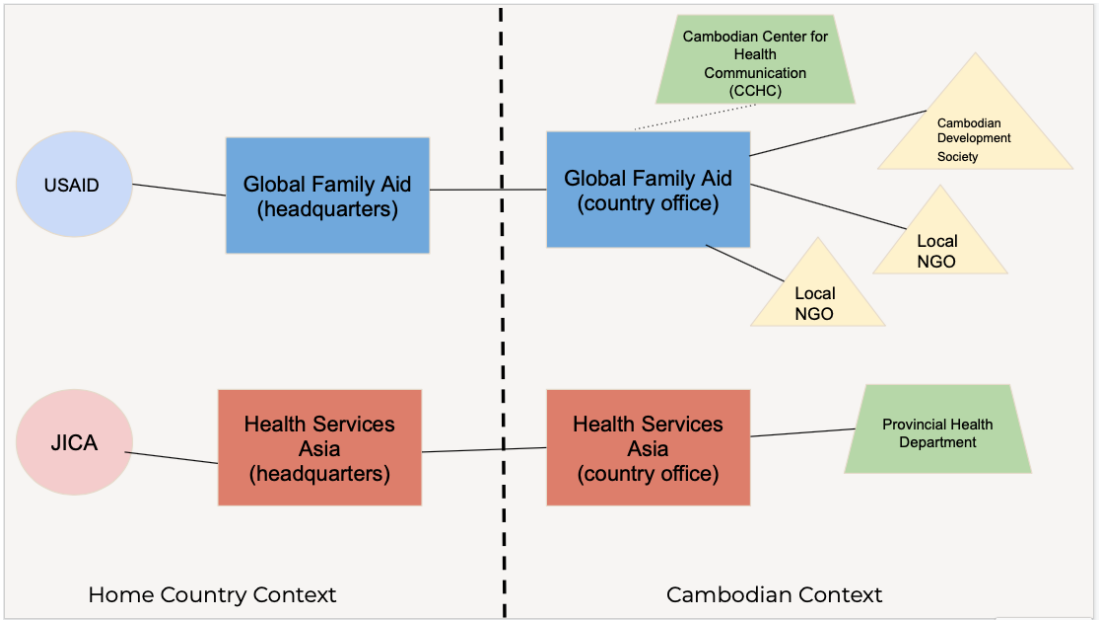
To implement a study of aid chains, I conducted a multi-sited ethnography over the course of seventeen months. First, in the Spring of 2018 and in the fall of 2019, I conducted approximately three months of research in Washington, D.C. This included 16 in-depth interviews with INGO headquarter staff. Three interviewees worked at Global Family Aid while the others were employed by other D.C.-based INGOs implementing health and gender programing. I also conducted interviews with two employees of USAID in Washington D.C. Finally, in order to get a general sense of the rhetoric of the sector, I observed at eleven international development conferences and workshops in Washington D.C. Of these events, GFA staff participated in seven.

During the 2018-2019 academic year, I was based in Cambodia where I carried out approximately 11 months of fieldwork. I spent four months observing in a Japanese INGO country office, Health Services Asia (HSA). I observed program implementation, staff interactions with visiting headquarters staff, and HSA's work with its local implementing partner, the Provincial Health Department of Stueng Treng[1]. Next, I spent four months observing in a U.S.-based INGO country office, Global Family Aid (GFA). I also observed GFA's cooperation with its government partner, the Cambodian Center for Health Communication (CCHC). After that, I conducted two and a half months of ethnographic observation in a local NGO that implements GFA programming, Cambodian Development Society (CDS).

Finally, in the summer of 2019, I spend three months in Tokyo. There, I conducted 18 interviews with staff in INGOs, of whom four work for HSA. I also conducted two interviews with staff from the Japanese bilateral agency, JICA and one from the Ministry of Foreign Affairs. Additionally, I attended seven international development events in Tokyo and HSA participated in two observed events. Please see Figure 1 for a simplified representation of the two aid chains in this study.

[1] Locations have been changed to preserve anonymity.

Figure 1



Through interviews in INGO headquarter offices and donors as well as observation at development events in Washington D.C. and Tokyo, I analyzed how INGOs understand the goals of international development and how programs are constructed. I carefully noted the rhetoric used to describe the program goals, ideal beneficiaries, and the best ways to advance developing countries. I also inquired about interactions between headquarters staff and country office staff, the NGO sector more broadly, and donors.

During observation in country offices and local implementing partner organizations, I investigated local stakeholder perceptions of, and interactions with, INGO headquarters and expatriate staff based in Cambodia. Furthermore, I accompanied local staff to observe the implementation of project activities, allowing me to watch the interactions of practitioners with local beneficiaries who are the target of development programming, as well as the interactions between employees of country offices, Cambodian NGOs, and government officials. Ethnographic observation in both INGO country offices and local NGOs provided me with data on how programs are adapted to fit the Cambodian context. Furthermore, observing both (1) how programs are developed and then, (2) how they are communicated to the practitioners who implement them in local communities provided insight into the role different actors along the aid chain play in constructing and translating national variation in INGO programming.

I also supplemented my ethnographic data with in-depth interviews with development practitioners in INGOs, local NGOs, and donors working in the gender and health sectors in

Phnom Penh, conducting 124 interviews in total (see Table 1 for interview breakdown). These interviews took place during preliminary data collection in the summers of 2016, 2017, and during the 2018-2019 academic year. Interviewees were recruited both through 'snowballing' from connections I had made with other INGO practitioners and through cold calling. In interviews, I inquired about the personal and professional histories of practitioners, their role in their INGO or NGO, and their goals for the intended beneficiaries of their work, as well as for themselves. This allowed me to gain a more general sense of the sector, where the INGOs in which I observed fit in, and how the culture of the Cambodian development sector might impact INGO work. Finally, I also supplemented my data with trips to NGO libraries, using resources there to investigate ten previous JICA and seven previous USAID health and/or gender programs. This data provided additional insight into the types of programs funded by each bilateral donor over time, and enabled me to discern whether my aid chains are consistent with more general patterns.

Table 1

Organization	**Number of Interviewees**
Donor Country Context	
Japanese Donor Organizations	4 (2 orgs)
Tokyo-based INGO Headquarters	19 (16 orgs)
U.S. Donor Organizations	3 (1 org)
D.C.-based INGO Headquarters	16 (11 orgs)
Cambodian Context	
Japanese INGO Country Offices	27 (25 orgs)
U.S. INGO Country Offices	24 (20 orgs)
Local NGOs	27 (25 orgs)
Europe or Australia-based INGOs or bilateral agencies	5 (5 orgs)

Conducting a multi-sited ethnography in three different nations required careful reflection about how my own positionality may shape my data collection and affect my understanding (DeVault 1996). To gain insight into the Cambodian development sector, I attended UW Madison's Southeast Asian Studies Institute over two summers to study Khmer language, history, and culture, and I had intensive language tutoring over two summers of preliminary data collection in Phnom Penh. Nevertheless, my position as an American inevitably shaped how participants responded to me. In Cambodia, being white and American holds inescapable power

dynamics in terms of relations with Khmer NGO workers. For instance, Khmer staff would often complain to me, an external researcher, hoping a foreigner might be better able either to convince expatriate staff to change some practices or to aid them in getting external funding. Khmer language skills and ethnographic observation were essential, enabling me to examine differences in how workers speak in English with donors compared to in Khmer with community members and governmental officials.

Second, with minimal Japanese language skills, I inevitably missed nuances during my data collection in Japanese NGOs. However, due to their international work, all development practitioner interviewees in Japan spoke English. Additionally, in my Japanese NGO field site, English was the main language spoken in common between Khmer and Japanese practitioners in Cambodia. Nevertheless, in Tokyo, in order to attend development events, I hired a translator. Moreover, in Japan, I collaborated with scholars at Kyoto University who aided me in developing my understanding of the Japanese NGO sector. Finally, in Washington D.C. and more broadly, I needed to be reflective about my own embeddedness in the U.S.'s development imaginary, particularly my own assumptions about the need to challenge gender inequalities in developing nations.

After the completion of my fieldwork, I open coded ethnographic notes and memos, interview transcripts, and textual data to look for thematic patterns and themes that may emerge (Charmaz 2006). Once I identified substantial patterns, I created a specific thematic coding sheet and investigated all notes and interviews for these themes [see Appendix 1]. Next, I wrote memos about how the substantive codes relate to one another and existing scholarly knowledge, eventually building up to general topics and an outline, which became the dissertation chapters presented here.

INGOs in the Cambodian Context

Cambodia has one of the highest concentrations of nongovernmental organizations (NGOs) in the world (Frewer 2013). Many date from the immediate post-Khmer Rouge period, when the UN Transitional Authority assisted in the formation of a new government in Cambodia, and numerous international funding opportunities attracted international NGOs from around the world. Yet, currently, local and international NGOs in Cambodia face an increasingly complex political landscape. Cambodia is controlled by a single political party, the Cambodian People's

Party (CPP), which has been progressively restricting NGOs that promote human rights, democracy and collective action. For instance, in 2015, the CPP adopted the Law on Associations and Nongovernmental Organizations, commonly known as the LANGO, which gives the government power to strictly regulate NGOs and to limit their advocacy or democracy promotion work, even the right to shut down organizations that fail to comply (Human Rights Watch 2018).

While this is a challenge for civil society actors broadly, the degree to which it affects INGOs varies. Some U.S. funded INGOs face political repression, and even those U.S. INGOs that successfully partner with the Cambodian government must be careful to maintain government approval in order to continue operating. Thus, development practitioners in U.S.-based aid chains must negotiate this constraint. Additionally, two other events caused many European and U.S.-based donors to decrease funding to the nation. First, in 2016, the World Bank promoted Cambodia from a lower income nation to a lower middle-income country. Second, in 2017, the CPP outlawed the main opposition party, the Cambodian National Rescue Party, ensuring a CPP victory in the 2018 national election. Due to these circumstances, donors from the United States and Europe, which have long provided the bulk of funding to Cambodia's NGO sector, began to commit fewer resources.

In contrast, Japanese aid is embedded in a larger trend in which East Asian nations maintain growing influence in Southeast Asia. China's rapid economic growth and growing political clout has also created a strong shift in Southeast Asia's geopolitical landscape. In the past ten years, Cambodia has seen increasing foreign direct investment from South Korean, Chinese, and Japanese companies (Open Development Cambodia 2021). These trends are manifest in the Cambodian development sector in a growing number of loans from China to develop infrastructure, and a growth in the number of aid chains originating in Japan and South Korea. Furthermore, consistent with the fourth plank in Cambodia's National Development Plan, the Cambodian government is now emphasizing regional integration and intra-Asia relations. The upshot of these trends is that the funding offered by the Western nations, and the United States in particular, is no longer as powerful as it once was.

In this context, Japanese INGOs are forging a different relationship with the Cambodian state than the one developed by their American counterparts. The Cambodian state's orientation articulates well with the organizational culture of Japanese INGOs, which are more likely to

implement development programs through or with the Cambodian government. Thus, as Global Family Aid and Health Services Asia organize aid chains and identify local partners, they find the Cambodian context offers different obstacles and resources.

Why Women's Health Programming?

The U.S.-based INGO, Global Family Aid (GFA) and Japanese INGO, Health Services Asia (HSA) both receive funding from their nation's bilateral agency, USAID and JICA respectively, to implement women's health programs in Cambodia. In part, INGOs implementing women's health activities were selected as the focus of my study because women's health is a priority area in Cambodia for both JICA and USAID. Additionally, though, women's health is a particularly rich site to study the question of national variation in aid chains. The provision of health services and solutions to health problems are not neutral but deeply shaped by societal and cultural norms (Foucault 1973; Carpenter and Casper 2009; Swidler and Watkins 2017). This is particularly true for women's health topics, such as maternal health and family planning, spaces where a society's norms around women's sexuality and the role of mothering impact healthcare provision (Connell 2012; Klausen 2015).

Feminist scholars have long recognized that ideas about gender relations, motherhood, and femininity are bound up with conceptions of national advancement and progress (Abu-Lughod 1998). Women's place in society is linked to economic ascent, preservation of cultural traditions, and modernity (Balogun 2012; Hoang 2015). For instance, Esacove (2010) examines a public campaign for HIV prevention in Malawi, supported by the Malawian government and international development organizations. In it, HIV prevention is organized around understandings of the moral categories 'risky' and 'healthy' sex. Risky sex, from which one might get HIV, is enacted by 'backwards' and promiscuous villagers who live in rural areas and engage in 'traditional' practices, such as widow cleansing. In contrast, despite the fact that HIV rates are higher in urban areas in Malawi, healthy sex is understood to take place within the confines of modern, urban, committed, heterosexual, and gender equal coupling. Cultural understandings of gender, sexuality, and health are deeply embedded in notions of societal progress and modernity.

Nevertheless, as discussed above, NGOs can also provide the space for practitioners and communities to contest long held cultural understandings. NGO practitioners encounter global

health ideas and contest taken for granted healthcare understandings in their own nations (Davis 2007; Noonan 2002). Thus, women's health is an area in which development practitioners in the U.S., Japan, and Cambodia might have particularly dedicated visions of a mother's or woman's place in a developed society due to the cultural norms of their own nation. Such norms may enter into the construction and implementation of program activities and be contested by other practitioners in the aid chain. For this reason, national variation across INGOs is likely to be particularly visible in women's health programming. Below, I provide a brief summary of the women's health activities of each INGO in this study.

Global Family Aid (GFA) is implementing 10-million USD USAID health project over five years. Aside from its USAID project, GFA also implements numerous projects for other international donors from the U.S. and Europe in the areas of maternal health, family planning, and malaria prevention. However, for the purposes of comparison to HSA's JICA project, this study focuses on GFA's largest project and its staff, a USAID project on 'health behavior change.' This project aims to promote health behavior change across multiple interconnected health sectors including water, sanitation, and hygiene (WASH), maternal and child health and nutrition, family planning, and malaria in five different provinces across Cambodia. To implement the project, GFA partners with the government sub-agency, the Cambodian Center for Health Communication (CCHC) as well as private clinics. Additionally, GFA sub-grants to local NGOs, like the Cambodian Development Society (CDS) to implement health activities in specific provinces. GFA maintains a three-story country office in Phnom Penh but staff travel frequently to monitor implementing partners or meet with local level health officials.

Health Services Asia (HSA) is conducting a maternal and newborn health project with approximately 1 million USD in JICA funding over a four-year period. HSA works only on one project in one province, Stueng Treng. It maintains a few corporate donors and individual sponsors and those funds are used to conduct supplemental activities for the same project. HSA partners with the provincial health department and the local levels of government beneath it to assist public health officials in implementing maternal and child health services. It maintains approximately twelve full time staff on the project. The organization does not implement any other projects or work with any other partner organizations, such as local NGOs. HSA has a small office in Phnom Penh where upper-level staff work on occasion but the majority of its work is conducted from its provincial office in Stueng Treng. As we can see, the programs and

practices of each INGO are distinctive – in the next section, I introduce my argument for why this is the case.

Development Imaginaries & Articulation

I find two processes create the variation that exists in Global Family Aid (GFA) and Health Services Asia (HSA)'s program activities, practices, and aid chain organization. First, I argue that the political economies, diplomatic priorities, and nonprofit cultures of the U.S. and Japan manifest in distinct *national development imaginaries* or interpretations of the best way for society to develop. Practitioners in donor agencies and INGO headquarters, like many of us, live and work based largely in a specific nation. This means they conduct their work embedded in the existing norms, institutions, and practices around development at their disposal (Berger and Luckman 1967; Davis 2007; Djelic 2008). As they develop the programs their organization will support, and interpret often vague or lofty global norms to 'empower women' or 'end poverty,' practitioners draw on the dominant schemas within their nation's development imaginary about the role that governments, markets, and nonprofits should play in solving social problems.

As we will see in the following chapters, staff at GFA describe their mission as "empowering women and mothers to be informed healthcare consumers"; they implement programs that engage public, private, and civil society organizations. In contrast, Japanese staff at HSA explain their maternal health program as helping women access effective public health services and gain knowledge about family nutrition to become "modern Asian mothers." Each development imaginary displays a distinctive understanding of how to advance women's health and the role that the state, private actors, and civil society should play in it. National development imaginaries will be discussed in-depth in the next chapter.

Second, national development imaginaries and their resulting program activities and goals *articulate* in the Cambodian context in ways that generate differential program outcomes as well as practitioner and local stakeholder understandings of gender, healthcare, and national development. Development programs and practices articulate or take on new meanings as they travel to new contexts, through the agency of local stakeholders, existing power relations, and the construction of new subjectivities. In the articulation process, development imaginaries are communicated along, and shaped by, the dynamics of aid chains, providing distinctive opportunities and constraints for practitioners in their broker role.

For instance, HSA largely hires local managers who are male and medical experts. It does so because to implement its programs in close cooperation the Cambodian state, it needs male experts who can create strong relationships with male public health officials. Yet, the unintended outcome of these friendly relationships is that Khmer staff from HSA and public health officials decide together that it is best to reject HSA's program directive to ignore traditional medical practices because they believe addressing them is beneficial for communities. This form of articulation is only possible because the aid chain originating in Japan provides the opportunity for close practitioner-state official relationships, relationships other INGOs do not foster. Articulation will be considered more fully in Chapter Five.

Analyzing the two above processes, this dissertation illustrates the causes and consequences of INGO variation in development outcomes. To do so, the manuscript is broken into two major sections. First, I examine the existence of development imaginaries in headquarter contexts. Chapter Two dives deeper into the definition of development imaginaries, analyzes the U.S. development imaginary, and then, explains how its imaginary manifests in women's health programming in Washington D.C. Chapter Three investigates the Japanese development imaginary and its impact on women's health programming in Tokyo.

The second part of the manuscript moves to the Cambodian context. Chapter Four provides pertinent background information on the development space, gender, and women's health in Cambodia. Then, in the next three chapters, I show how each development imaginary articulates in the Cambodian context with distinct outcomes for programming, state partnerships, and practitioner identities. Chapter Five examines the distinctive outcomes of women's health programs implemented at GFA and HSA and the gendered consequences each entail. In Chapter Six, I look in-depth at the different types of partnerships that GFA and HSA pursue with the Cambodian state and the reactions of state officials to these partnerships. Chapter Seven considers the distinctive backgrounds of practitioners employed by GFA and HSA and the effect of working in each organization on practitioner identities. Finally, the manuscript concludes with some reflections about what these differences in development assistance might mean as part of larger geopolitical changes taking place in Asia. Taken together, the chapters demonstrate that what flows along global aid chains is not just money and material aid, but also contending ideas about the role of the state, the market, civil society, and gender in the development process.

Chapter Two
Conflicting Demands of a Global Hegemon: The U.S. Development Imaginary

The United Nations' Sustainable Development Goal Three includes the target: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births."[2] In Cambodia, the U.S.-based INGO, Global Family Aid (GFA) and Japanese INGO, Health Services Asia (HSA) work towards this target. Yet, as described in the introduction, GFA and HSA implement very different development programs. HSA focuses on strengthening government-provided maternal health services in Cambodia. Contrastingly, GFA promotes a diverse maternal and reproductive healthcare sector, including private providers and civil society organizations. Why does this variation occur? While local practitioners in Cambodia play an essential role in modifying programs, I argue these differences cannot be explained by examining the Cambodian context alone. Variation in development programming exists before it ever travels to Cambodia, as practitioners in the global North define activities and construct metrics for program success embedded in their own nation's vision of what it means to develop.

The next two chapters investigate this process. How do practitioners in donor and headquarter organizations define who is in need of aid and what types of development programs should be supported? When they do so, what different ideas and resources are at their disposal? To answer these questions, in this chapter, I investigate the regulatory and funding characteristics of each sector as well as the *national development imaginaries* in which practitioners in the U.S. and Japan are embedded. To define national development imaginaries, I draw inspiration from two concepts which come from cultural sociology and critical development studies, respectively. The first concept is "national cultural repertoires" and the second is "imagined geography" (Lamont and Thevenot 2000; Said 1978).

National cultural repertoires are defined as "relatively stable schemas of evaluation that are used in varying proportion across national contexts. Each nation makes more readily available to its members specific sets of tools through historical and institutional channels"

[2] https://www.un.org/development/desa/disabilities/envision2030-goal3.html

(Lamont and Thevenot 2000: 8). Thus, national cultural repertoires are schemas, or "sets of cognitive associations, developed over repeated experience, that present information and facilitate interpretation and action" (Hunzaker and Vanlentio 2019: 950). Due to distinct political and cultural histories, different schemas are more readily available to evaluate social problems in various nations. For instance, due to its two-party system, the U.S. maintains two sets of dominant schemas for interpreting the problem of poverty, constructed by its liberal and conservative parties respectively (Hunzaker and Valentine 2019). The concept of national cultural repertoires is employed to analyze patterned variation in dominant schemas in a nation without essentializing national culture (Lamont and Thevenot 2000).

Comparative studies have illustrated how dominant national cultural repertoires create cross-national variation in understandings of numerous social problems including race, sexual harassment, obesity, and immigration (e.g., Benson and Saguy 2005; Camus-Vigue 2000; Lamont 2000; Saguy, Gruys, and Gong 2010). For instance, in the U.S., sexual harassment is understood within two dominant logics– the prioritization of the market and a history of minority group-based conceptions of inequality. Women are understood as a group facing discrimination and this discrimination, in the form of sexual harassment, hinders workplace productivity and professionalism. In contrast, France lacks the U.S. history of identity or group-based politics; therefore, sexual harassment is framed as a violation of individual rights, violence, and an abuse of power (Saguy 2000).

Similarly, NGO programs offer specific interventions into social problems in developing nations, like poverty, limited health services, gender inequality, or child nutrition (Silvey and Rankin 2010). As practitioners in the global North construct solutions for developing countries and beneficiaries, they interpret these problems within dominant understandings about the role that the market, state, and nonprofit actors play in solving social problems in their own nation. For instance, as we will see below and in Chapter Six, reflecting dominant assumptions about healthcare systems, U.S. INGOs are more likely to construct programs that support private and nonprofit healthcare actors, not unlike the U.S.'s own hybrid health system.

There is an iterative relationship between institutions and cultural repertoires. Institutions reinforce some sets of schemas over others, making actors more likely to draw on particular ideas (Lamont and Thevenot 2000; Sewell 1992). For instance, legal structures such as Civil Rights Law and Title IX, reinforce the centrality of group-based discrimination schemas in the

U.S. Finally, dominant sets of schemas can be challenged and changed (Sewell 1992). For example, groups demanding cultural change can challenge institutions and policies, as the #MeToo movement did when it modified dominant understandings of sexual harassment in the U.S. workplace.

However, I diverge from the repertoires tradition to use the term national development *imaginaries* in order to highlight a crucial characteristic of power and knowledge production in international development. The second concept I draw inspiration from is Edward Said's (1978) conception of "imagined geography," which he describes as the imaginative boundaries drawn around the "Orient" and the "Occident." Said critiques a long history of development theory in which it is assumed that the Orient or the non-West is on a similar development trajectory and can be compared to the Occident or the West of an earlier period.

With the end of colonization, the imagined geography has changed -- donors in the global North (Western and non-Western) imagine needy beneficiaries in underdeveloped nations in the global South-- but the spatial notion in considering problems of development remains (Escobar 1995; Goldman 2005; Mitchell 2002). To address problems presented by development, practitioners in the global North are required to imagine 'a distant Other,' be it an underdeveloped nation-state or a beneficiary in need. Then, practitioners construct specific programs to advance or assist this Other, drawing on dominant sets of schemas available to them in their nation. Practitioners' representations of others in need, while presented as neutral visions, are often representations of what practitioners embedded in a specific nation believe to be the best path to 'development.' Ideas produced about development in the global North have power because the material resources that flow along global aid chains are not distributed equally. Donors and INGO headquarters provide much needed funding to local stakeholders but only for projects practitioners in the global North believe to be best.

In consequence, it is necessary for NGO practitioners in the global South to respond to national development imaginaries and resulting project goals that come from headquarters and donors. This is certainly not to say that development is simply "donor driven" or that the dynamics of aid chains can be reduced entirely to donor demands. As we will see in later chapters, Cambodian practitioners modify development programs and resist particular requirements. Yet, in order to gain funding, local practitioners must represent their government or fellow Khmer citizens as "needy" beneficiaries or "imagined others" in ways that articulate

within the national development imaginaries extant in particular donor nations. In aid chains, the national development imaginaries of donor and headquarter organizations have a powerful influence on program construction. Then, different types program activities constructed in donor nations provide distinctive opportunities and constraints for practitioners in Cambodia.

Therefore, the term, 'imaginary' is used here to denote the power dimensions embedded in the practice of international development, in which practitioners in the global North imagine a distant Other in need of development. For this reason, when describing the Cambodian context, I do not use the term Cambodian development imaginary. While Cambodians certainly have ideas about how their nation should develop, the imagining of an Other in need of aid and then, the exportation of those ideas to recipient nations is a key piece of the definition of national development imaginaries. As Cambodia does not currently provide other nations with substantial aid, I do not use the term development imaginary to describe the Cambodian context.

Thus, the concept of national development imaginaries clarifies the importance of the dominant schemas that practitioners draw on, given their specific national context, to solve problems of development for an imagined, distant other. Investigating national development imaginaries in this chapter and the next, I disaggregate the ideas about development produced by specific nations in the global North. The current chapter explicates the U.S. development imaginary and the next one examines Japan's. This chapter examines, first, the historical origins and existence of the U.S. development imaginary, and then, how the imaginary manifests in the case of women's health programming. However, before I investigate the U.S. development imaginary, it is necessary to clarify the relationship between national development imaginaries and the global norms discussed in the Introduction.

Global Norms versus National Development Imaginaries

As discussed in the Introduction, ample research has illustrated that INGOs are embedded in a global field of development organizations, which creates isomorphism in the formal rhetoric of programming (Boli and Thomas 1999; Keck and Sikkink 1999; Krause 2014; Moghadam 2005). There are recognized global norms about what international aid programs should do and these norms absolutely influence the formal rhetoric and construction of development programs in the U.S. and Japan. At a rudimentary level, INGOs from both nations implement programs

and practices that are formally similar, such as conducting baseline surveys, implementing development "projects," and following them up with monitoring and evaluation practices.

However, I argue that research has overemphasized the study of isomorphic forces, ignoring the heterogeneity among development programs produced by the global North. As we will see below, the U.S. imaginary does engage dominant global norms such as gender equality, democracy, poverty reduction, and civil society promotion. Nevertheless, while formally similar, the content of INGO programming differs significantly. Additionally, U.S. INGO practitioners interact in a 'global field,' attending global development conferences and networking with development organizations around the world. Yet, the majority of an INGO practitioner's time is spent within one nation. This has two important consequences for the integration of global norms into INGO programs and practices.

First, global norms like 'women's empowerment' or 'poverty reduction' are vague and multi-vocal. Thus, they can be interpreted in a number of ways. Practitioners encounter specific nonprofit regulations, foreign aid agendas, and national development imaginaries in their domestic development sector. Thus, in creating proposals and programs for developing nations, global norms are interpreted and modified through a domestic lens before ever traveling to recipient contexts. In this chapter and the next, I examine this process of interpretation in the U.S. and Japan.

Second, the norms and practices of domestic development sectors also impact global norms. Sarah Stroup asserts "there is no global civil society, but rather a set of national civil societies coming into more frequent contact with one another" (2012: 13). As practitioners from domestic development sectors interact globally, new domestic interpretations or norms can shape development policies in the international field. For instance, the Burakumin, a minority group in Japan, established an INGO with UN consultative status and helped to develop new global human rights norms around discrimination, ethnicity, and work (Tsutsui 2018). Thus, attending to domestic development policies and practices can also tell us how global norms change. Yet, in this process, actors from some nations have more power to define global norms than others. For instance, as I illustrate below, the U.S. played a prominent role in the construction of global norms due to its place in the international order in second half of the 20th century. In the next section, I examine the historical legacy from which the U.S. development imaginary draws inspiration.

Origins of the U.S. Development Imaginary

It is important to examine the history of nonprofits and foreign aid in the U.S. context before explicating the U.S. development imaginary for two reasons. First, the background of nonprofits and INGOs in the U.S. contexts provides insight into the present-day material opportunities and constraints INGOs face, such as the funding and regulatory environment. Second, the dominant sets of schema or development imaginary that practitioners in Washington D.C. employ to interpret development problems are based on a distilled or a selective rendering of the nation's development history.[3] For instance, in the U.S. development imaginary, free markets and open trade are held up as essential keys to development in the U.S. and around the world. This is despite the fact that the early American state developed by using tariffs and other forms of protectionism (Hobson 1997).

Selective histories are institutionalized, for instance by being put into formal documents. JICA's formal reports describe Japan's history of family planning and maternal public health practices from the early 1900s to today without mentioning the U.S. occupation (JICA 2005). Yet, it is well known the occupation's robust public health interventions impacted Japanese health practices in those areas (Koikari 1999; Nishimura 2008). Thus, the dominant schemas that make up development imaginaries integrate a post-facto narrative about how a nation developed and the role played by the government, the market, and nonprofits in that development process. For this reason, below, I first investigate the history of U.S. nonprofits in relation to the state and market and second, I detail the history of foreign aid in the U.S. and the role of INGOs within it.

Nonprofit history in the U.S.

The U.S. has a long culture of volunteerism and nonprofit organizing (Tocqueville 1835; Skocpol, Ganz, and Munson 2000). After the American Revolution, the early American state found taxation and service provision difficult to implement, leading to a rise in nonprofit service provision. Tax relief for public organizations started in the early 1800s. Furthermore, throughout the 1800s, Christian charities and religious organizations provided nonprofit services such as education, healthcare, orphanages, and eldercare (Hammack 2002). Thus, many nonprofits in the

[3] This raises the question of who selects the history which informs development imaginaries. From the data I have, I believe imaginaries, like repertoires, are constructed in a development sector over time with dominant actors constructing narratives that are challenged and modified over time. However, more historical research is needed to fully answer this question.

U.S. have origins in religious institutions and due to this history, scholars estimate 60 percent of current U.S. nonprofits are faith-based (Heist and Cnann 2016; Stroup 2012).

After the Civil War, nonprofit organizations grew in size and number. National federated groups began to make up a significant percentage of nonprofit organizations, a precursor to the U.S. INGOs with offices in multiple nations (Skocpol, Ganz, and Munson 2000). Nonprofit growth continued from the late 1800s through the 1920s. Nonprofit groups advocated for issues like women's suffrage, prohibition, and child labor rights in the Progressive Era. These organizations also helped the nation mobilize for WWI and WWII. While membership declined during the Great Depression, there were increases in voluntary membership after each World War (Skocpol, Ganz, and Munson 2000). In conjunction with growing federal subsidies and the increased affluence of American citizens, the nonprofit sector grew considerably after WWII.

After 1960, another wave of nonprofit expansion occurred for several reasons. First, American affluence continued to grow. Americans could increasingly afford to purchase services from and provide support to nonprofit organizations, such as private education or patronage of the arts. Second, in contrast to New Deal legislation that emphasized government services, the Great Society programs enacted by Lyndon B. Johnson increased subsidies to nonprofits. Third, nonprofit organizations' role in social organizing increased during the 1960s and 70s. Nonprofits were involved in the wave of mobilization in this era, including the Civil Rights Movement and the Anti-Vietnam War movement (Hammack 2002). The 1969 Tax Reform Act liberalized charitable organization status and tax exemptions for donors. With these legal changes, nonprofits were provided with the opportunity to act as influential interest groups and partners to the state.

By the 1980s, nonprofits were referred to as the 'third sector' in the U.S., increasingly influencing political and business sectors and providing employment opportunities (Muslic 2017). Specifically, while nonprofits made up 1 percent of the job market in 1900, they accounted for 3 percent in 1960, and 9 percent by 2000 (Hammack 2002). Currently, non-profits in the U.S. work in a 'friendly' regulatory environment, with tax exemptions for donors who make contributions (Stroup 2012). Voluntary groups incorporate at the state level as nonprofit organizations and apply for tax-exempt status by registering with the IRS. Tax-exempt status is relatively easy to obtain (Reimann 2010). The U.S. has the largest nonprofit sector in the world with 1.56 million nonprofits registered in the U.S. in 2015 (National Center for Charitable

Statistics 2018; Stroup 2012). The sector comprises an estimated 5.4 percent of the GDP in the U.S. and the U.S. government itself is a generous donor to the sector (National Center for Charitable Statistics 2018). For contrast, in France, nonprofits encounter a very different regulatory context. The French state has not historically relied on nonprofit services. There, nonprofits face a much more complex regulatory environment, limited tax breaks on donor giving, and minimal state funding (Stroup 2012).

This unique nonprofit history is intricately linked to the U.S. style of social service provision. Currently, the U.S. welfare state is considered a liberal regime. This means the government provides only needs-based or means-tested benefits for low-income individuals (Esping-Andersen 1990). The U.S. government relies on the market or nonprofits to provide needed welfare services to its population, with only limited state stopgap measures. Due to the government's long-term reliance on nonprofits, a friendly regulatory environment, and government funding for nonprofit service provision, the nonprofit sector contributes to the U.S.'s decentralized delivery of social welfare services.

U.S. Foreign Aid & INGOs

This active U.S. nonprofit sector paved the way for the early and rapid proliferation of American INGOs. It is after World War II that foreign aid, as we know it, originated. It began due to the need for aid in war-torn Europe. In 1943, before WWII as officially over, the United Nations Relief and Rehabilitation Administration, representing 44 nations, was formed to provide aid to Europe. The Administration provided funds to Europe, and later Asia until 1947, with the U.S. providing the majority of the aid. Then, in 1947, as the Cold War begins, the U.S. extended aid to the governments of Greece and Turkey as well as several Asian countries to combat the influence of the USSR and China. By the 1950s, the U.S. was providing foreign aid to the majority of developing countries that remained independent (Lancaster 2007). Since it originated during the Cold War, U.S. foreign aid strongly emphasized the global spread of capitalism and democracy, which continues to be a priority area in U.S. foreign aid today (Kilby, 2017; McMichael, 2016).

In a Post-WWII world, the U.S. saw the need for European reconstruction in order to secure capitalism and stability in the Western world. For this reason, in 1948, President Truman signed The Marshall Plan, which distributed billions of USD in bilateral aid to Europe and Japan. This served multiple purposes, including encouraging U.S. investment in these nations,

facilitating international trade, creating political loyalties to the U.S. and shoring up "free" Western nations (McMichael 2016). In addition to being the major foreign aid donor at this time, the U.S. Treasury was also at the center of another key geopolitical movement in the post-WWII era, the 1944 Bretton-Woods Conference. At the conference, two international banks, the World Bank and the International Monetary Fund were established to guide the reconstruction of the world economy. These banks, in which the U.S. was and continues to be an influential member, provide capital to re-establish the global economy and promote trade. But, the World Bank and the IMF also played a powerful role in constructing and promoting the dominant path towards capitalist development around the world (McMichael 2016). Due to the U.S.'s geopolitical position in the post-WWII moment, the U.S. is the major player in the origin story of foreign aid and international development.

The U.S.'s original motivations for providing foreign aid differ from other nations. For instance, while they did face pressure from the U.S. to share the burden of international aid, Britain and France began providing foreign aid in the 1950s and 60s with different motivations. The origins of foreign aid in Britain and France were deeply influenced by colonial legacies. In the late 1950s, Britain set up a system for aid to India and France granted aid to numerous former African colonies. They did so to preserve their influence in the region, improve economic relations, and protect French and British settlers in former colonies (Lancaster 2007). Such motivations are in contrast to the U.S.'s political battle against communism and the Soviet Union. But what role do INGOs play in the origin story of foreign aid?

Globally, since 1850, more than 25,000 INGOs have been founded (Boli and Thomas 1997). At the forefront of this trend, U.S.-based INGOs increased in number throughout the twentieth century. Before WWI, despite a large number of domestic nonprofits, there were only a small number of internationally-oriented nonprofits in the U.S. But, the number of INGOs in the country begin to multiply after WWI, and even more so after WWII. Like foreign aid, many originated to provide relief and assistance to victims of the war in Europe. For instance, the Cooperative for American Remittances to Europe (later the E is changed to stand for everywhere) or CARE was founded in 1945 to provide care packages to WWII survivors. In 1946, a committee of INGOs was set up to advise the U.S. government on relief work. Cooperation between INGOs and the government was rare at this time and only took place in a

few other nations. For instance, in Sweden an INGO committee was created to advise on and manage foreign aid in the early 1950s (Lancaster 2007).

U.S. INGOs were highly engaged in the creation of the international development community we know today. In 1945, 42 INGOs from the U.S. served as advisors at the San Francisco meeting where the United Nations was founded. Many INGOs originated during the Cold War era to encourage cross-cultural communication, democracy, and protest nuclear armament (Iriye 1999). However, in the 1950s-60s, the majority of U.S. foreign aid still focused largely on infrastructure and economic development, with limited funding for INGOs. It was not until the early 1970s that funding sources for INGOs expanded markedly in the U.S.

Starting in the 1960s, the U.S. revised its foreign aid practices, making important changes to the role INGOs played in U.S. foreign aid. In 1961, John F. Kennedy founded the United States Agency for International Development (USAID). Distrust in unaccountable state bureaucracies and failure of infrastructure projects meant there was a demand for more measurability of aid and its impact. The Kennedy administration introduced results-based management, commissioning a consulting group to create the logframe. The logframe emphasized smaller and measurable development projects, ideal for INGOs. As will be discussed below, to this day, the logframe and ensuing results-based management techniques remain dominant in the U.S. development sector and have become prominent globally (Krause 2014).

In the 1970s and 1980s, with the global debt crisis, calls for changes to development and foreign aid escalated. In the 1973 Foreign Assistance Act, non-profits were identified by the U.S government as important partners for grassroots development, after which funding to INGOs increased (Stroup, 2012). As a leading promoter of neoliberal policies globally, the U.S. was also an early promoter of INGOs as ideal non-state social service providers (Reimann 2009). Following the U.S.'s lead, foreign aid donors globally increasingly relied on INGOs to deliver a portion of their development assistance throughout the 1990s (Fechter 2019). Additionally, the end of the Cold War in 1991 created a space for new political rationales for international aid to emerge. Yet, the end of the Cold War also made the argument for aid less compelling in the U.S., and foreign aid became increasingly subject to budget cuts (Lancaster 2007).

Due to its geopolitical hegemony throughout the 1990s, the U.S. played a powerful role in constructing the international development community, alongside multilateral organizations and donors from Europe. Nevertheless, international norms set by the community of nations also

impact the domestic development sector in the U.S. By the late 1980s and 1990s, increasing calls for 'soft aid' shifted the nature of development programs from primarily infrastructure projects to an increasing focus on programs like health, education, and gender.

Currently, there are around 5,600 U.S. non-profits that work internationally and about three-quarters of these are considered INGOs that provide development and aid programming abroad (Stroup 2012). The U.S. government relies heavily on INGOs to help dispense foreign aid. Although USAID does not publish the exact number, scholars estimate approximately 28 percent of USAID's aid budget is funneled through INGOs (Tarnoff 2015; Stroup and Murdie 2012). For comparison, only in Scandinavian nations do we see INGOs play a similarly large role in international aid. For instance, the Swedish government channels about 30 percent of its aid through INGOs (Bigsten, Isaksson, & Tengstam 2016). This is much more than most developed nations, such as Britain, where about 5 percent of bilateral funding goes to INGOs (Stroup 2012).

Doing Development in Washington D.C.

Now, having outlined the history of nonprofits and INGOs in relation to the market and the U.S. state, I will turn to my empirical data to investigate how this history is distilled into the U.S. development imaginary. However, before doing so, I examine a final factor that influences the development imaginary of the U.S.: the current characteristics of and financial practices in the American development sector. In analyzing the U.S. development sector below, I primarily utilize my own data from INGO and donor interviews in Washington D.C., but I also cite secondary sources in order to provide other relevant information, such as donor funding amounts or comparisons to other nations. Of the 11 D.C.-based INGO headquarter organizations in my NGO sample (discussed in greater detail below), two are specifically focused on gender and empowerment, including women's health; four are health organizations that implement women's health activities; and, five are general development organizations that implement both health and gender programming.

U.S. Donor & Development Sector Characteristics

In the U.S., INGOs gain a significant portion of their funding from government and foundation grants. We can contrast this generous situation to INGO funding in Britain and France. In Britain, internationally oriented charities gain the majority of their funding from

private donors and in France, INGOs depend on private donations and the EU for funds (Stroup 2012). However, alongside this generosity comes limitations: the U.S. government places restrictions on the amount of money nonprofits and INGOs that receive state funding can spend on lobbying, discouraging political advocacy. In contrast, while the French state is less generous with nonprofits, no such regulation exists in France. French nonprofits take a much more prominent activist role, mobilizing to protest the government's foreign policies (Stroup 2012).

U.S. developmental assistance funding is fragmented, with approximately 26 agencies providing some sort of development aid. However, the most prominent organizations are USAID and the State Department, which control over half of U.S. development assistance funding (Stroup 2012). All but one of the U.S.-based INGO headquarter organizations in my sample gain funding from USAID. USAID offers multiple funding schemes for which INGOs can apply. First, there are grants and cooperative agreements, and while there is no set amount, these are often for smaller amounts, such as 1 million USD. These are provided for "implementation of programs that contribute to the public good and in furtherance of the objectives of the Foreign Assistance Act" (USAID website 2020). USAID also offers contracts, to "obtain goods and services" for which INGOs must be 'contract ready' i.e. able to provide the money upfront and be reimbursed later (USAID website 2020). Contracts provide larger amounts of funding, which typically only large INGOs have the capacity to disperse. One bilateral agency interviewee explains this issue, stating "yes, the pool of NGOs for contracts is small. Do you know that many NGOs that can disperse 20 million dollars?"

Thus, while on average, U.S. INGOs gain 20 percent of their annual budget from the government, USAID funding makes up a much higher percentage of the budget for most large INGOs in the U.S. (Stroup, 2012). Large, professionalized INGOs with annual revenue of over 2 million USD per year make up only 12 percent of the American INGO sector. But, the U.S. government has a strong preference for funding these organizations, channeling over 50 percent of funding through large INGOs (Reid and Kerlin 2006). This is particularly true in the health sector, where funding amounts are often between 10-40 million USD. Due to my interest in health programming, large organizations (with operating budgets of over 2 million USD per year) are overrepresented in my sample, comprising 9 of the 11 D.C.-based INGOs I interviewed.

Typically, USAID puts out a program description or request for proposals with detailed program requirements for each grant and contract.[4] INGOs compete, particularly for contracts, with private consulting firms in Washington D.C. One participant from a health INGO, Health 4 All, describes this process cynically stating, "basically it makes us USAID contractors." Contracts and grants are also often granted to INGOs in partnerships. Depending on the nature of the program, USAID might cooperate with other international foundations or corporate partners to act as donor organizations to three or four INGOs and/or consulting firms.

U.S. foreign policy is also highly dependent on the U.S. Congress, meaning USAID funding can change with shifts in U.S. foreign policy priorities or congress members' interests. One bilateral agency interviewee explains:

> Yeah, they [congress] definitely gives money for specific areas and then we have to work in those areas….It seems like some Congress people have areas that are very important to them so they always make sure there's funding that goes to that, or sometimes they learn about a new issue….I also know that different Congress people have funders that care about specific stuff and it can change.

Yet, while Congress dictates funding areas, it is important to note that USAID also maintains a decentralized structure (Swiss 2018). This means country missions (the USAID office located in the country or region where aid is provided – there are 60 total mission offices around the world), staffed by both locals and Americans, have considerable influence in designing the types of activities that should be conducted within funding areas. A bilateral agency employee tells me that the role of D.C. is to act as a 'check and balance' on missions and make sure they are in line with USAID's initiatives. But, country missions, guided by the general topics coming from D.C., such as 'climate change,' design specific program activities to be implemented in consultation with D.C. staff.

In the U.S. development sector, the norms of constructing projects that emphasize measurability and efficiency are highly influential. Because they compete with private organizations for project funding, INGOs feel pressure to prove themselves as effective at service provision as their private sector counterparts. As a result, INGOs in the U.S. are highly results-focused and professionalized. Such priorities are quite distinct from other Western nations. For instance, in France, INGOs are often run by political activists and emphasis is

[4] Interviewees do report that USAID occasionally hosts co-creation workshops to gather the input of INGOs before putting out the call for proposals.

placed on the principles and process of development aid, rather than the end results (Stroup 2012).

In consequence, monitoring and evaluation (M&E) have particular importance in the U.S. context. While all nations evaluate the effectiveness of their development projects, the U.S. has an enormous number of requirements for doing so (Stroup 2012). USAID funded INGOs are required to complete more quantitative, lengthy, and complex M&E reports. For instance, JICA's website offers a few reports detailing how to conduct a successful evaluation of partnership projects. USAID provides monitoring and evaluation/reporting guidelines that are hundreds of pages long. USAID also holds countless online webinars and in-person conferences, flying practitioners from all over the world to D.C. for workshops on monitoring, evaluation, and learning (the newest terminology for M&E) and numerous requirements that must be followed to implement a USAID project. These include baseline and endline surveys, quarterly reporting, and external and internal evaluations at the end of the project. Such an emphasis on measurability and reporting contributes to the highly professionalized U.S. development sector with well-paid, credentialed, expert practitioners who evaluate projects using the latest metrics. This in contrast to both Brain and France where reliance on volunteers in the INGO sector remains high (Stroup 2012).

Professionalization allows INGO employees pronounced influence in the U.S. development sector. The U.S. government depends on INGOs to help provide services and promote its interests abroad, and create new and innovative development solutions at home. INGO practitioners in the U.S., deemed legitimate development experts, are provided with numerous opportunities to advise and cooperate with government agencies. This is in stark contrast to France where the state has long been considered the primary foreign aid actor. There, INGOs had no formal mechanism for accessing the government until the 1990s, and these mechanisms continue to be seen as largely a formality, allowing INGOs little real influence on foreign policy (Stroup 2012). The U.S. government's historical alliance with nonprofit actors lays an important foundation for the role of INGOs in international aid.

However, the U.S. government is not the only donor in the U.S. sector. INGOs in my sample are also supported by organizations in Europe or Australia, multilateral organizations, other INGOs, foundations, and a few private donors. Most headquarter offices provide long lists of over 50 donors on their annual reports and websites. Obtaining and managing this number of

funders again contributes to the professionalization of the sector. INGOs often have teams of staff who seek out new funding opportunities and manage the requirements of existing donors. Corporate, foundation, and multilateral donors will be discussed briefly below.

All D.C.-based INGOs in my sample also maintain some form of funding from companies. Typically, corporate funders are U.S-based companies, although five organizations have corporate funding from organizations in Europe or Asia. Large American companies often fund INGOs to implement aid activities connected to the company's work abroad. For instance, Levi's provides funds to INGOs to deliver women's health and educational activities in garment factories. Interviewees explain there is no set way to gain corporate funding. Some corporations have invited INGOs to apply for funding being provided through the company's CSR programs. Other companies are put in touch with INGOs and provide funding more informally. INGO staff also report that corporate funding can be more flexible than government funding, since companies lack the same reporting requirements as USAID. However, corporate funding is also more limited and insecure, ending abruptly in times of economic decline.

The U.S. has the largest foundation sector in the world, providing INGOs with numerous funding options (Stroup 2012), and some INGOs receive funding from international foundations, multilateral organizations, and bilateral agencies in European nations and Australia. One employee on the grants and contracts team at a general INGO, Justice International explains her job, informing me she should be called the 'person of esoteric knowledge.' She goes on to tell me about each day on the job:

> Questions can come from all sides… so one day… I have scheduled something for 10:00 with a country office tonight about DFID grants… answering a country office question on USAID agreements earlier today, trying to figure out a prime award with a corporate donor earlier, and I was working with the State Department yesterday. So, yeah, it's all gambits of the organization… because any contract or grant you work with is going to affect all parts of the organization… because most funders, when they give a grant or agreement they're going to dictate certain ways their business has to be done…and I need to know all of those agreements.

Most INGO interviewees report numerous donors are great for organizational sustainability but it can sometimes be difficult to manage conflicting donor demands. One interviewee explains her organization has an international foundation donor that wants to provide an abortion training in Africa, but their religious donors will pull out if they provide such a training. Despite conflicting donor demands, U.S. INGOs have access to a greater number of funding opportunities than

INGOs in many other nations. All 11 INGOs in my sample had access to enough funding to maintain program activities in over seven developing countries.

The above history and organizational characteristics provide the foundation for the U.S. development imaginary. For instance, donor demands for results-based management, U.S. distrust for ineffective bureaucracies, and limited separation between the private and nonprofit sectors are strong explanatory factors for the dominant market logic we see in the U.S. development imaginary. However, the development imaginary also creates and reinforces organizational practices. For instance, the U.S. belief in grassroots civil society promotion leads to INGO emphasis on funding local NGOs and grassroots organizations in recipient nations. It is important to keep the intertwined nature of institutional practices and dominant schemas in mind as we move to detail the U.S. development imaginary in the next section.

The US. Development Imaginary

Contained within development imaginaries are distinctive visions of the ideal role of the state, market, and nonprofit or civil society organizations in the development of a society. Should the state provide social services and limit the market? Should the market have primacy with civil society organizations filling in welfare gaps? In the U.S. context, the market is primary, the state plays a limited role in service provision, and a large, professionalized nonprofit sector fills in gaps in social services. Relatedly, INGOs are expected to cooperate with the public sector to fill in service gaps, compete with private actors, and nurture a vibrant civil society. One INGO interviewee states, "it's not easy, there's a web of actors and interests that we need to attend to as an INGO. Relations must be maintained with local civil society, business groups, the private sector, donors, other INGOs, and the recipient government."

The close cooperation between the INGO sector, state, and market is a distinctively American configuration. In Britain, INGOs are considered primarily charities, strictly separated from the private sector. In Sweden, there is a strong emphasis on INGO political advocacy as civil society agents, separating them from the state and market (Lancaster 2007; Stroup 2012). Below, I examine how the close cooperation between INGOs, state, and market is reflected in the U.S. development imaginary, as practitioners construct programs to fund and implement in

recipient nations.[5] I find headquarter organizations typically decided to emphasize one or two of the three poles-- civil society, the state, or the market-- in their work, depending on the organization.

Civil Society. In the U.S. development sector, despite spending limitations on lobbying, it is assumed that INGOs are 'civil society organizations' that represent citizen interests. Therefore, INGOs lobby the U.S. government to improve development practices within budget limitations. Lobbying in the U.S. context does not look like the collective mobilization in which INGOs participate in France. At the lobbying event of a gender empowerment INGO, International Equality, we go to the offices of Congresspeople and provide their staff with pamphlets detailing how to improve USAID budget allocation. Furthermore, all but two practitioners I interview in D.C. discuss the need for INGOs to promote civil society in their work abroad. They define doing so as INGOs advocating for or encouraging local partners to promote issues like human rights, women's empowerment, grassroots mobilization, and democracy in recipient nations.

To illustrate, consider a half-day conference on women's empowerment. The conference takes place at the Rayburn House, a Congressional office building on Capitol Hill in D.C. At the event, multiple INGO practitioners, two private consulting firm directors, and a USAID administrator present on how to improve development activities addressing women's economic empowerment. A representative from International Equality stands up to address the audience. She argues that to improve women's economic empowerment, we need to promote civil society and lobby governments. Looking over to the USAID administrator in attendance, she exclaims, "we need to push the U.S. government to broaden its funding for women's empowerment!" She goes on to say that INGOs need to support the efforts of local partners in recipient nations to lobby their governments. Partners should demand policy change on issues that can prevent women's economic independence, like land tenure regimes that don't allow women to inherit property.

U.S. donors also assume INGOs play an important role in cultivating civil society and representing the needs of beneficiaries. Speaking at a large development conference, one USAID representative states, 'we need the civil society and citizen-centered approach of NGOs in

[5] I must remind the reader, that the existence of a development imaginary does not mean dominant schemas are always followed in the same way and never challenged. Not every headquarter organization in my sample adheres to every aspect of the national development imaginary.

development." However, as we have seen above, this vision that INGOs are separate, civil society organizations that represent the interests of citizens isn't entirely accurate when U.S. INGOs are expected to work in close cooperation with private actors and state agencies at home and in recipient nations. Thus, as we will see below, INGO headquarters differ in the degree to which they promote civil society advocacy alongside public and private sector cooperation.

The State. U.S.-based INGOs often partner with the U.S. government and recipient country governments to effectively fill in gaps in social services. State cooperation does not always fit easily beside demands for civil society promotion. To illustrate, let's consider a conversation from a large development conference in Washington D.C. At a panel on the 'future of the development profession,' the CEO of a general INGO, Stop Poverty, explains that INGOs need to do two things: partner with recipient governments to 'fill in gaps' for service provision and 'make demands on governments for citizens.' In the U.S imaginary, recipient nations take on a dual character. Sometimes recipient governments are to be lobbied, but, in other cases, they are a cooperative partner to improve service provision. U.S.-based INGOs often walk a fine line between promoting civil society in recipient countries and partnering with recipient country governments. One interviewee at Justice International explains this tension:

> So, okay… in order to implement a health program, for the most part you probably need a partnership with the ministry, right? But, you may have other programs that are criticizing government for lack of rights, so that can jeopardize that type of relationship you have to function…it's difficult… so for the most part, what we have to do… we're not, you know, out there doing any type of aggressive advocacy. Instead, our approach in a lot of our offices is trying to find space where civic actors can work on issues without really upsetting the balance. They're not, you know, running out to Parliament and banging on the door type…you have to find a way to do both…

Relatedly, one INGO program director at Global Family Aid (GFA) explains how his organization does both, stating, "I mean government exists, but these grassroots NGOs also exist. So, part of our job is to build up these grassroots NGOs to have a voice but also get their government to listen to them." The imagination that INGOs play the role of both service providers in partnership with recipient states and, in a more limited way, civil society organizations that lobby developing country governments for policy change is similar to the role nonprofits play in the domestic U.S. context.

Further illustrating the dual character of recipient states in this imaginary, in Cambodia, USAID funds a civil society project in which local NGOs lobby the Cambodian government to

increase women's political participation and political freedom. Yet, it simultaneously funds two INGO health projects in which it expects its partners to cooperate with the Cambodian state. As a U.S. government agency, it is committed to democracy, civil society, and human rights, but it also wants to engage the public sector and encourage successful diplomatic ties with recipient countries. This often leads to the watering down or making 'regime compatible' democracy or human rights advocacy projects (Bush 2015). Additionally, USAID often encourages INGOs to fund local NGOs to lobby their governments, which my bilateral interviewee explains "lessens the image of American intervention."

However, not every headquarter organization in my sample accepted the need to limit advocacy. A feminist INGO in my sample, Gender Action, prioritized social movement building for reproductive rights and other feminist topics. This emphasis on mobilization means it is blacklisted by several recipient nations, including Cambodia, where it worked without government permissions. This choice, not to find a balance between government partnership and advocacy, marginalized Gender Action in terms of funding. The organization only sometimes receives USAID funding, generally in smaller amounts and indirectly via other INGOs; it works with fewer foundations than other INGOs in my sample; and, it maintains a larger number of international donors, often from Scandinavia.

An interviewee who works at Gender Action explains the problem with many U.S. donors is that "they are all about quick change and results." She explains that for her organization,

> Changing the attitudes-- that's the biggest problem. It's not enough to just give people quality education, or access to abortion clinics if they cannot use it… until attitudes and systemic problems are addressed, the technical fixes don't work… so for so many donors [the] monitoring and evaluation piece… is about things they can measure, but they're not actually solving problems… Some governments… the money comes with a lot of restrictions and I think the U.S. is one of those and so yeah, we don't want to have funding from the U.S. government…We want to get money from organizations that want to fund long term change in gender attitudes and systemic issues through movement-building in the Global South.

However, Gender Action is an outlier, as the majority of large U.S. INGOs limit civil society activities in order to successfully partner with recipient states.

The Market. In the U.S. development imaginary, the market is the primary solution to social issues, such as poverty or healthcare, and INGOs fill in gaps where the market fails. Additionally, INGOs are in competition with private organizations for USAID funding and often

work in cooperation with them to implement programs in recipient nations. In consequence, U.S. INGO activities are steeped in market logic, borrow management techniques from the private sector, and often privilege market solutions, such as microfinance.

Throughout workshops and interviews, participants employed market rhetoric to describe development activities. Interviewees use the terms supply and demand side to describe programming, refer to beneficiaries as consumers, and detail the need to 'increase program effectiveness and efficiency.' At a workshop on 'The Future of Development' one speaker discusses at length the need for INGOs to be flexible businesses that 'follow the Google model.' At others, I listen to presentations entitled, 'Your Mission Statement is a Commodity' and 'Best Practices for Branding Your INGO.'

The market model enters program design and proposal writing. An interviewee from Global Family Aid's D.C. office states, "To design a new program, first we have to diagnose what is needed by identifying our target customers and health need, assess the market, and profile target consumers." In program design, INGO activities also combine the rhetoric of civil society and the market. A program director at Justice International details his organization's new program in Cambodia, which will promote female entrepreneurship. He states:

> So, we're looking at women's economic empowerment and how that links to…women gaining confidence to be active in the civic space…I think it's an interesting theory of change, if you will, to see the linkages between, like, you know, kind of a skills development in one area, the economic, leading to changes in another somewhat separate area, the political.

Numerous interviewees refer to international development as a 'business' or a 'market' and the need to 'pitch program activities to donors.' Figure 2 illustrates the market rhetoric in USAID's grants and contracts process.

Figure 2

Interviewees also held a firm belief in competition as the preeminent way to achieve effective programming. A Health 4 All interviewee describes what she thinks is problematic about 'relationship driven' donors in Europe.

> There's just… some donors, who are just really relationship driven and again, the question is, if you're that relationship driven, how are you ensuring you're getting best value? Because you can't, you're not competing or anything and maybe you don't care. But, how do you really get new innovative thinkers and ideas in the door?

Competition is a fact of life for INGOs in Washington D.C with a large number of private firms and contractors competing for the same funding opportunities.

D.C. practitioners also firmly believe the market is the best way to make INGO and local partners' programs sustainable in the long run. Several interviewees explain their INGO is using or starting to use tactics like microfinance, 'impact investing', social impact bonds, or the selling of services, such as evaluations or trainings. For comparison, I only found the goal to make INGO programming sustainable through market mechanisms in one Japanese NGO. Thus, in the U.S. development imaginary, it is assumed the public sector and nonprofit organizations support the market and, in an ideal future the market will eventually provide a large portion of the funding for INGO programming.

In the next section, I analyze how the U.S. development imaginary impacts women's health programming. However, before doing so, I must note a final prominent finding. In Washington D.C., practitioners often discuss the need for the U.S. to be a 'thought-leader' or role

INGOs play in continuing the U.S.'s influence in the international community. INGO practitioners in D.C. aspire for their work to impact global norms. I did not encounter this goal in Tokyo.

Empowered Consumers: Women's Health in the U.S. Context

Above I provided a general overview of the U.S. development imaginary and its vision of the role the state, the market, and INGOs should play in international development. Now, I will investigate how the U.S. development imaginary manifests in the case of women's health programming, taking a concrete look at how practitioners interpret global norms through their national development imaginary to solve women's health issues. As discussed above, practitioners selectively draw on their own nation's development history when considering how to solve social problems in recipient nations. Policies that regulate families and women's bodies abroad are constructed within cultural and political norms of Japan and the U.S. (Klausen 2015). Therefore, before examining the construction of women's health programs in D.C., I briefly discuss relevant background on gender and healthcare policies.

Gender & Family Policy in the U.S.

As discussed above, the U.S. has a residual welfare state, providing limited social services to push citizens into the market. This system is profoundly gendered. Despite a brief period of expanded maternalist welfare policy between 1900 and 1920, the American welfare system is based on a male breadwinner model (Skocpol 1992; Orloff 1993). We see the development of the modern U.S. welfare state in the 1930s with New Deal welfare legislation (Goldfield 1989; Katz 2010). In 1935, Roosevelt signed the Social Security Act into law. Thus, the U.S. established its dual-welfare system. There were policies set up for, at this time, largely male workers such as social security and unemployment insurance. Then, there were less generous programs for non-workers such as the Public Assistance Programs for the Needy, Aged, and Blind (replaced by the Supplemental Security Income program in 1972) and Aid to Families with Dependent Children" (AFDC) (SSA 1999).

After the New Deal era, welfare becomes associated with 'socialism' due to the red scare and policy-makers turned against state spending. In the 1960s, U.S. social spending increased again with the passage of assistance like Medicare and Medicaid. However, from the late 1970s through the early 2000s, social assistance for the very poor in the U.S. continued to shrink (Katz

2010; Shannon 2017). Specifically, in 1996, the Clinton administration ended AFDC, replacing it with Temporary Assistance to Needy Families (TANF). TANF provides only limited, short-term assistance to the poorest families, pushing women (who make up over 80 percent of recipients) into the labor market (US Department of Health and Human Services 2012).

Relatedly, paid parental leave is not a legal entitlement in the U.S. The only federal policy available for leave is the Family Medical Leave Act (FMLA). Passed in 1993, the Act allows employees to take 12 weeks of unpaid leave to care for a family member, new child, or recover from a serious illness. However, it comes with stipulations—for example, only employers with 50 or more employees are required to comply with the FMLA and employees must work full-time for twelve months before taking leave. Thus, over half of American workers are either ineligible or unable to take leave due to financial restraints (Arellano 2015). Furthermore, childcare in the U.S. is largely privatized, meaning access to care and quality of that care is dependent on ability to pay (Estevez-Abe 2014; Moller, 2002). Contributing to the lack of work-family policies is the fact that American feminists have historically centered female labor force participation and individual equality. For example, the U.S. is a leader in passing sexual harassment policies that support women workers (Zippel 2006). Yet, it is one of the least generous developed nations in terms of work-family policies (Arellano 2015).

Despite the lack of public support, American women also face strong social pressures around mothering. While there are important class and ethnic differences in mothering expectations, American women contend with dominant norms of "intensive mothering," which expect mothers to be the most important person in a child's life. Mothers should be available to nurture, listen, and explain. Yet at the same time, mothers are expected to be ideal workers (Hays 1996; Vandenberg-Daves 2014). These dual-pressures notwithstanding, the majority of middle- and lower-class women continue to participate in the labor force, since their family depends on their salary. Fifty-seven percent of American women are in the labor force. Among married couples, 48.8 percent are in families in which both spouses work, in 19.1 percent of families only the husband works, and in 6.8 percent of families, only the wife is employed (U.S. Bureau of Labor Statistics 2019). Single mothers are even more likely to be in the workforce, at a rate of about 77 percent (Livingston 2018; U.S. Bureau of Labor Statistics 2019). Privileging market solutions and individual responsibility, the U.S. promotes a model of women's empowerment

through economic independence, paying little attention to the particular difficulties women face balancing work and family (Cummins & Blum 2015).

In short, historically, the U.S. configuration of market, state, and society originally emphasized a male breadwinner model but it has a dual earner reality. As we will see below, the assumption that in a successful, developed nation women and mothers should be in the labor force has consequences for the types of women's health activities U.S donors and INGOs support. However, first, we must assess the second institution that impacts women's health programming, the U.S. health system.

Health Policy in the U.S.

The U.S. healthcare system also reflects the residual welfare model described above. It is disjointed and complex due to distinct policies passed at different points in history; it relies heavily on private and nonprofit actors for service provision; and public healthcare provisions are largely means-tested benefits for the poor (Quadagno 2010; Stevens 2008). Despite recent changes, the American government largely works under the assumption that healthcare is a commodity to be purchased in the market. Thus, it does not engage in centralized healthcare planning (Lew et. al. 1992; Quadagno 2010). In the U.S system, the best healthcare goes to those who can afford to purchase it.

After WWII, with backing from President Harry S. Truman, there was a movement for universal healthcare. However, politicians and interest groups regarded universal insurance to be 'socialist' and blocked its passage. By the 1960s, privatized health insurance became a competitive industry, gaining lobbying power and a vested interest in the market healthcare system (Stevens 2008). Nevertheless, citizen groups have also played a strong role in pushing through many health policies, such as civil rights activists advocating for Medicare and racial equality in hospital access (Quadagno 2010). Thus, the U.S. healthcare market operates with piecemeal government subsidies at strategic points for particular groups (Stevens 2008).

For many years, government subsidized health insurance in the U.S. was made up of three types of insurance. First, Medicaid, which subsidizes medical costs for people with limited income. Second, Medicare, which provides coverage to elderly and disabled populations. Third, the government also subsidizes private health insurance by allowing employers to deduct premiums for employee healthcare from their taxes. Additionally, employees are not taxed on health benefits received from employers (Lew et. al. 1992; Quadagno 2010). More recently,

there have been changes to the health system (Quadagno 2010). In 2010, Obama signed the Affordable Care Act (ACA) into law, giving higher subsidies to business for insurance provision and helping the uninsured purchase affordable health coverage. Then, the ACA faced rollbacks under the Trump administration. Currently, it is not yet clear what changes will be made to ACA provisions under Biden.

Nevertheless, the U.S. health system is incredibly dependent on private actors and nonprofits in the provision of services. The majority of ACA government coverage is contracted out to the private sector (Campbell and Morgan 2012). Hospitals in the U.S. are most often run by nonprofit organizations (56%) with the rest being for profit (25%) or state (18%) run (Elflien 2019). There is a strong dependence on charities and nonprofits to provide supplemental aid to cover the healthcare needs of the poor (Katz 2010). In the U.S. healthcare system, we, again, see a pattern consistent with the overall development imaginary -- the prominence of the market, while nonprofits and the state fill in service gaps.

Specific to women's health, the story of maternal and child health legislation in the U.S. begins with a wave of 'maternalist legislation." Women's activism in the Progressive Era and rising concern around child labor in the early 1900s lead to the creation of the Children's Bureau to fund child welfare programs in 1912 (Skocpol 1992; Lesser 1995). Then, in 1921, the Sheppard-Towner Act was passed, which funded research and education on maternal health and infant care was passed. The act helped to greatly reduce infant and maternal mortality in the U.S. until it expired in 1929 (Lesser 1995). After its expiration, Title V of the Social Security Act passed in 1935 included grants for states to extend and improve maternal and child health services (Lesser 1995). It was modified in 1981 to become block grants, increasing state and local control over the funding (Lu et al. 2015). Sadly, Title V has not proved to be entirely effective, as the U.S. currently faces increasing maternal death rates.

Today, American women are expected to seek prenatal and delivery care in the healthcare market described above. Upper- and middle-class women with private insurance typically seek care earlier and have better birth outcomes. Delivery costs are high in the U.S., approximately 10,000 USD for a vaginal birth without complications. As insurance typically covers only a percentage of this cost, women pay an average of 4,000 USD per vaginal birth (Khazan 2020). For women in poverty, ideally, government programs subsidize care. In the 1980s, Congress expanded Medicaid to increase coverage of women in families below the federal poverty level

with the goal of lowering infant and maternal mortality rates (Ellwood and Kenney 1995). Finally, Title V continues to play a dual role, providing funding for maternal and child health programs for states and acting as a last resort payer for maternal and infant health services (Lu et al. 2015).

However, these policies are falling short, as the American healthcare system faces increasing challenges in providing adequate maternal health. Among OECD nations, the U.S. has one of the highest maternal mortality rates (MMR). In 2000, the rate was 9.8 maternal deaths to every 100,000 live births. By 2014, it had more than doubled to 21.5 maternal deaths to every 100,000 live births (Nelson, Moniz, and Davis 2018). Maternal death is highly racialized. In the U.S., black women are three to four times more likely to die in child birth than white women, regardless of class background (Delbanco et al. 2019). One of the largest contributing factors to the high MMR in the U.S. is access to adequate healthcare, particularly prenatal care. Other contributing factors include high rates of cesarean sections, increasing age of first pregnancy, and high rates of obesity and diabetes (Nelson, Moniz, and Davis 2018).

When it comes to reproductive health, birth control has been a contentious issue in the U.S. for over a century. In 1914, Margaret Sanger introduced the term 'birth control' in her newsletter called *The Woman Rebel*. She was indicted for breaching obscenity laws soon after. By 1916, despite attempted legal restrictions, Sanger opened the first birth control clinic in the U.S. By 1930, there were 55 birth control clinics in the U.S., which grew to more than 800 in 1942 (Gibson 2015). In 1960, the birth control pill was approved by the FDA, and in the 1965 the Supreme Court ruling in Griswold v. Connecticut ruling gave married couples the right to use birth control. Then, in 1972, after high levels feminist mobilization around the issue, the Supreme Court legalized birth control for all citizens. In that same era, feminists pushed for safety improvements to the Pill (Gibson 2015).

Contraception is now widely available and commonly used by American women. In 2017, approximately 65 percent of women aged 15–49 in the United States were using contraception. The most common contraceptive methods used were female sterilization (18.6%), oral contraceptive pill (12.6%), long-acting reversible contraceptives, such as the IUD (10.3%), and male condom (8.7%) (CDC 2018). Reproductive control is understood to be essential for women to succeed in the workforce. However, in recent years, there have been conservative

movements to restrict access, such as the "conscience clauses," which allows employers to refuse to cover birth control due to their religious beliefs (Gibson 2015).

Finally, abortion is also a contentious issue in the U.S. In 1973, Roe v. Wade made abortion legal nationally. Since legalization, abortion has been a political hot button with strong "pro-life" and "pro-choice" movements (Luker 1984). Currently, there have been a number of laws restricting access to abortion on the state level by limiting the number of clinics that can legally operate or the number of weeks into pregnancy that doctors can perform an abortion (Beckman 2016). As we will see below, abortion is also an area where U.S. politics directly impacts foreign aid.

Thus, women's healthcare in the U.S. is broadly resonant with the development imaginary described above: women's health services are largely provided by the market with stopgap state and nonprofit services. It is assumed women need access to contraception in order to succeed in the workforce This legacy influences the types of women's health programs that are supported in the U.S. development sector. In the next section, I discuss the programs constructed at USAID and U.S.-based INGO headquarters.

The Development Imaginary in Action: Women's Health Program Construction in Washington D.C.

In this section, I examine the ways in which gender and health programming and practices are interpreted through the U.S. development imaginary. I begin by investigating USAID's priorities and then present data on INGOs in Washington D.C. First, USAID strongly emphasizes global gender norms in its development programming. Like all Western bilateral donors, USAID maintains a gender policy and promotes a gender and development framework (Swiss 2018). Its Gender Equality and Women's Empowerment Policy, states "Gender equality and female empowerment are now universally recognized as core development objectives, fundamental for the realization of human rights, and key to effective and sustainable development outcomes" (USAID 2012: 1). USAID and DFID's gender strategic goals are outlined in Table 2. The table illustrates the importance of gender equality as a global norm and the resulting similarity in the formal rhetoric of the two nations.

Table 2

DFID	USAID
• Challenge and change unequal power relations between men and women, and negative attitudes and discriminatory practices that hold women and girls back. • Build the inter-linked foundations which will have a transformational impact for girls and women: elimination of violence against women and girls; access to sexual and reproductive health and rights; girls' education; and women's economic and political empowerment, including an increase in women's participation and leadership in conflict prevention and peacebuilding processes, at community and national levels. • Protect and empower girls and women in conflict, protracted crises and humanitarian emergencies, to rebuild their lives and societies, by listening to their needs and by increasing the meaningful and representative participation and leadership of women. • Leave no girl or woman behind. Focus where progress is slowest because of multiple discrimination or disadvantage, including for girls and women with disabilities. • Integrate gender equality in all our work across the board and track delivery through to results - on jobs, trade, tax systems and the world economy; new technologies; modern slavery; climate change; nutrition; tackling AIDS; infrastructure; and peace agreements.	• Integrate gender equality and female empowerment into USAID's work: This policy will be implemented by integrating approaches and actions to advance gender equality and female empowerment throughout the Program Cycle. • Pursue an inclusive approach to foster equality: This policy is inclusive of all women and men, girls and boys, regard less of age, sexual orientation, gender identity, disability status, religion, ethnicity, socioeconomic status, geographic area, migratory status, forced displacement, or HIV/AIDS status. • Build partnerships across a wide range of stakeholders: USAID will partner with a wide range of key actors to ensure that our efforts to increase gender equality and female empowerment are coordinated and nonduplicative, and reflect country priorities. This includes host governments; international and host country civil society; women's organizations; the donor community, foundations; lesbian, gay, bisexual and transgender advocates; and the private sector, including women-led businesses. USAID's partnerships with local individuals and organizations will capitalize on and leverage their passion, experience, and achievements, while building their capacity as advocates, leaders, and voices for change. • Harness science, technology, and innovation to reduce gender gaps and empower women and girls: USAID interventions to promote gender equality and female empowerment should make bold, imaginative, and creative use of new technologies and innovations that hold great promise for increasing men's and women's health and well-being. • Address the unique challenges in crisis and conflict affected environments: USAID's work in crisis, conflict affected, and fragile states will facilitate women's participation in peace processes and decision-making, promote women's roles in conflict prevention and recovery, strengthen its efforts to pre vent and protect women from gender-based violence, ensure that relief and recovery efforts are specifically responsive to the different needs and priorities of women and men, and enable women's safe and equitable access to assistance, services, and livelihood support. • Serve as a thought-leader and a learning community: USAID will measure performance in closing key gender gaps and empowering women and girls. Monitoring and evaluation methods should include indicators that measure progress toward gender equality and women's empowerment • Hold ourselves accountable: Promoting gender equality and female empowerment is a shared Agency responsibility and depends on the contribution and collective commitment of all staff.

However, this comparison also suggests some differences between the British and U.S. development imaginary. While there are strong similarities, USAID does not place as much emphasis on power relations between men and women or women's rights. We can also see USAID's commitment to INGOs that cooperate not only with civil society, but also with the public and the private sector. This commitment is not present in DFID's goals.

Relatedly, interviewees confirm that while economic empowerment is important globally, it holds particular prominence at USAID. One USAID staff member affirmed that, "we really value empowering women in the workforce." She went on to explain that "economic empowerment is a huge focus right now, particularly technology and women's entrepreneurship is an up-and-coming initiative right now." USAID funds gender-specific programs but more often, gender is integrated throughout priority development sectors, like agriculture or health. This phenomenon makes it difficult to estimate exactly how much is spent on gender and development programming. Nevertheless, USAID's commitment to gender equality and women's empowerment can be seen in its rhetoric, integration of gender specific indicators into planning and evaluation, millions spent each year on gender-specific programs, and the number of gender experts on staff. In addition to its gender policy, another USAID document, ADS 205, provides practical steps for the integration of gender into each program and seven gender indicators for monitoring and evaluation. After the project is contracted out to an implementing INGO, the INGO must conduct a gender analysis for the program and integrate gender into the project following the steps provided by the ADS 205 document.

Second, since its inception in 1961, health has been a priority area for USAID (Himelfarb 2016). Unlike some of its other project areas, USAID actively promotes the need for state collaboration in health projects. State collaboration in health is considered necessary because of the scale of health system programming. A Health 4 All interviewee explains:

> For larger systemic, health change… so if you talk about local partners being the local government, for health organizations…our job is to make them [the state organization] more efficient or somehow more impactful…. So that almost defines everything we do… partly because that's what USAID is doing with health, our main donor, it's really a government-to-government agreement… to prioritize a certain large health project and then USAID looks for an implementer to do the work…

However, in contrast to JICA, USAID simultaneously funds grassroots advocacy and private sector partnership projects in the area of health. Another Health 4 All interviewee explains her organization works with the Cambodian government to regulate and improve education for

doctors but joins with grassroots organizations to advocate that the Cambodian government provide HIV services to marginalized populations, such as entertainment workers and LGBTQ individuals.

Finally, considering gender and health priorities together, maternal and child health has a prominent place in the development activities of USAID. The topic has been a mainstay of USAID programming since the late 1980s. In 1985 the Child Survival Initiative passed and maternal health was added to the initiative just a few years after. One Global Family Aid (GFA) interviewee tells me a story about the power of maternal health in U.S foreign aid. She reports hearing multiple accounts from Secretary of State staffers that Hilary Clinton used to walk through her office on the way to her desk and shout, "Let's save some babies people. Get working!" She states, "we speak the language of gender but it doesn't change that saving babies is a powerful motivator on all sides of the isle." In her mind, this is due to the fact that the U.S. Congress has enormous influence over USAID. "Saving babies" is something everyone in Congress can get behind.

USAID also invests in reproductive health activities. The 1970s to 1990s are widely considered USAID's 'golden age' of family planning activities. In 1968, the UN formally recognized women's reproductive rights as a human right. At this time, there was strong bipartisan support in Congress for population programs and the budget for the Office of Population grew from 5 million to 125 million USD between 1967 and 1974. By the mid-1990s, USAID funded family planning programs in 77 countries and it continues to be a key programming area, as it is "widely recognized modest families are better for economic development" (USAID 2012). Access to and use of modern birth control methods are understood as essential to enable women's economic empowerment. One USAID report justifies its women's health activities with the following statement: "Ensuring the survival and health of women is an imperative in its own right. But it is also a development priority because of the critical roles that women play in the nurture and education of their children as productive workers in their societies, as vibrant contributors of global economic growth, and as leaders in building democratic society" (USAID 2014; 17).

Reproductive health activities can be implemented as stand-alone programs but are more often integrated with maternal child health programming in USAID's Maternal and Child Health

Integrated programming[6]. As we see in GFA's programming, child nutrition and/or water and sanitation programs are also often implemented alongside maternal and reproductive health activities. Together, these programs are believed to increase the health of mothers and children.

Finally, abortion is an issue where U.S. policy directly impacts foreign aid. Despite large investment in global reproductive health services, at the Mexico City Conference in 1984, Ronald Regan introduced the global gag rule banning USAID funds be used by INGOs for abortion services (Petroni and Skuster 2008). Due to the politized nature of abortion in the U.S., the global gag rule was subsequently removed and then reinstated with successive changes in presidential administrations. After Obama left office, it was reinstated by Trump in 2017, and most recently, lifted by the Biden administration.

The U.S. development imaginary is illustrated by the priorities of USAID. It promotes working with government to increase health system regulation of services, with the private sector to create healthcare markets and 'cost-effective' approaches to women's health services, and with grassroots organizations to promote 'behavior change' in women and their families (USAID 2012). Moreover, in interpreting the global goal of gender equality, USAID puts female economic empowerment front and center.

While practitioners need to work within USAID's priorities in order to acquire funding, INGO practitioners can also interpret and modify donor priorities in program construction. Program construction happens in two stages. First, when INGOs are applying to get funding, staff write a proposal that meets donor priorities like improving maternal health outcomes, argues for the best way to achieve donor goals in the country, and makes the case for why their organization is best positioned to do so. Second, after a proposal is successful, INGO staff sit down again to discuss concretely how a program will be implemented. Both of these processes take place through numerous interactions and conversations between headquarters and country office staff. Country office staff are tasked with identifying beneficiary needs and partners on the ground while headquarters staff ensure program activities make sense within global norms, organizational mission, and donor priorities. One interviewee explains, "we [the INGO] have our own goals, the donor has requirements, and I need to ensure the country office is aligning with those." Examining program construction below, we can see how both global norms and the U.S. development imaginary impact it.

[6] https://www.mchip.net

First, four headquarter INGO interviewees explain that it is part of their job to help make programs "gender transformative" or "foster progressive changes" in "gender norms" and "the power relations between men and women." At the very least, programming has to be "gender sensitive" and consider "men and women's norms, roles and relations" as well as their "access to and control over resources." These are terms WHO and the UN promote to evaluate gender development activities.[7]

Most headquarter organizations maintain gender policies or strategies posted online. For instance, GFA maintains a gender policy on its website. The policy includes multiple parts, which address how gender equality can be pursued in its programming, partnerships, research, and internal operations. Unlike in Tokyo, where program activities addressing gender are extremely rare, all INGOs in my D.C. sample integrate activities directly addressing gender relations into program activities in multiple countries.

Specifically, when I ask how gender is addressed in GFA's programs, an interviewee explains:

> I feel very, very strongly that gender equity is an issue that should shift [what they are doing] every department at GFA. It's not a separate category of work. It's the way we should be doing our work, right, which is to understand-- we work in health. There's no part of health that isn't affected by gender roles. So, in every program that we run, we should be thinking about the way that gender inequities in gender roles are shaping people's access to and uptake of health services. We should be trying to-- the minimum is to make sure we're not doing harm by reinforcing gender norms that are destructive, right? In the ideal world we're trying to get smarter about them. We're trying to open access for women. We're trying to ensure that what we're trying to challenge norms that keep men from using health services or seeing themselves as people who deserve or need health services or even as a weakness. We're trying to make sure that other gender identities and sexual identities are being included and thought about and that we're doing that in a way that's also kind of rational and proportional to the overall health problem that we're trying to solve.

Practitioners in D.C. understand funding gender and health programs that promote global norms like 'gender empowerment' and 'reproductive rights' to be essential to their work as global civil society actors that challenge gender inequality around the world.

Additionally, all INGOs in my sample supported grassroots community groups or local NGOs to upgrade women's health services. For instance, Health 4 All works with local NGOs to implement trainings for sex workers on contraception. Practitioners understood supporting local organizations as key to supporting civil society in recipient nations. However, as discussed

[7] https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

above, practitioners balance civil society goals with the need to promote the public and private sector. Thus, there is limited discussion of collective advocacy or women's social movement-building (with the exception of Gender Action).

In part, this is because all headquarter organizations, except Gender Action, report working in cooperation with public health officials in differing capacities. For instance, International Equality helps several recipient nations evaluate and regulate the education system for midwives and gynecologists. Finally, about half of the INGOs in my sample engaged in private sector partnerships. One interviewee describes the need to evaluate supply and demand for reproductive health products and partners with a pharmaceutical company to effectively market family planning products to women. INGOs also maintain numerous programs emphasizing economic empowerment, microfinance, savings groups, and female access to capital.

In a further example of how market logic impacts program activities, at GFA, my interviewee tells me about their gender strategy and marketing of a sanitation project in India. She explains that by attending to gender, the team had "a big insight early on in the project which is that toilets have traditionally been marketed in India… well they were marketed to male family leaders as you should do this to protect your women, right, have a toilet in your house." Yet, with competing demands for household money, not enough men were buying GFA India's subsidized toilets. So, the team in India decides to do market research to be better able to promote toilet purchases. She explains their findings:

> We need to reframe toilets to something that's beneficial for the whole family, that it elevates your social standing and everybody's health," right? It's what's smart for families do -- is have a toilet for everybody, right? And then our sales really took off. That's a gender insight, right? That's gender-sensitive insight because they're characterizing this as something to solve a female problem is not effective. Characterizing this as something that benefits everybody is effective.

In this example, we can see the ways in which market logic in the U.S. development imaginary manifests in women's health programming activities. Thus, in the above activities, we can see how INGOs in D.C. work to integrate the civil society, state, and market demands of the U.S. development imaginary into women's health programming.

However, this does not mean that donor agency and headquarters staff do not critique or modify the U.S. imaginary and the dominant practices that proceed from it. Many interviewees are concerned that close cooperation between INGOs and recipient nation civil society

organizations, private sector actors, and state officials leave INGO staff a bit scattered. When I ask about challenges with the gender and development system, one interviewee from USAID explains that the agency has displayed an increasing level of commitment to gender integration since 2010. Yet, she worries that it is difficult for USAID missions and INGO implementers to fit gender in among many other program requirements and partnerships. She states:

> I feel like at USAID gender is becoming more of a priority area. But, I think sometimes in missions there's so many requirements that they have to follow, so many organizations they need to work with, that it can just feel like gender is one of many things they have to do.

INGO interviewees also express several concerns with gender and health programming ideas in implementation. Even when there is a high level of commitment to gender and health policies at the headquarters level, most interviewees report country offices have autonomy to modify and construct programming for their local context. One GFA interviewee explains the need to convert their broad gender strategy into concrete, implementable programming ideas that they can "sell" to the country office. Furthermore, headquarter staff are aware that reproductive health can be a difficult topic in many nations, and they work to find committed staff who can handle the topic with care.

Furthermore, some INGO interviewees in D.C. express concerns about the difficulty in measuring their aspirational rhetoric. It takes years to see if efforts at instilling "gender norm change" and addressing access to contraception pay off. One M&E specialist describes this issue as a "focus on outputs versus outcomes" and it's a challenge because donors only fund "for the life of the project and they're not providing funding for the retrospective 2 years later or 5 years later, so the kinds of things that they can measure tend to be more on the output [side], like number of trainings, number of people there, that sort of thing."

To contend with this, one grant writer explains that she tries to "find the grey space between what outcomes must be reported to donors and what INGOs can do on the ground." For instance, she changes a Catholic donor's abstinence training into a girl's education and empowerment training, but could still report the same outcomes. Consequently, headquarters staff also sometimes help local practitioners adapt programs to address local needs. Another interviewee reports that sometimes in interactions with donors she draws on other goals to convince them to reformulate their demands: "maybe they're (the donor) pushing for women in our program to have self-sufficient micro-businesses in six months, but that's not possible… I can push back on that by reminding them that we're not a business, and that we're also here to

work with the grassroots community and challenge gender norms." Thus, while the U.S. development imaginary impacts program construction and INGO practices, headquarters staff negotiate it by using schemas against one another.

The Imagined "Other"

Above I have detailed the history from which the U.S. development imaginary draws inspiration, analyzed the regulatory and funding characteristics of the U.S. development sector, defined the U.S. development imaginary, and illustrated the consequences of this imaginary in the case of women's health programming. However, we are left with one final question – in the U.S. Development imaginary, who is the Other that is the recipient of U.S. aid? In donor offices and INGO headquarters in both Tokyo and Washington D.C., development practitioners describe their organization's mission in generally similar terms. Their goals are 'to help people in poor countries,' 'upgrade the quality of life for people in developing nations,' 'advance the quality of services provided in developing countries,' or 'improve the lives of people in need.'

However, as we have seen, development practitioners interpret the activities needed to achieve the vague goal of aiding beneficiaries in developing nations within their national development imaginaries. Thus, in the U.S., donors and INGO practitioners imagine the recipients of their women's health programming to be a generalized woman who lacks information about women's health as well as the resources needed to gain access to the healthcare market. Fixing this problem means increasing the power of women vis-à-vis men in their households and communities, particularly through female labor force participation. Simply stated the imagined Other is a potential healthcare consumer in need of empowerment. Engaging in partnerships with local civil society organizations, the state, and the market, U.S. INGOs seek to empower this woman by providing her with community support groups, information, access to markets, and increased opportunities for income. In the next chapter, we will examine Japan's distinctive national development imaginary, as well as the women's health programming that proceeds from it and the imagined Other that benefits from it.

Chapter Three
"Phnom Penh is like Hiroshima": The Japanese Development Imaginary

In the previous chapter, I examined the U.S. development imaginary. I argued that when practitioners design development activities, they draw not only on global norms and perceived recipient needs, but also on the dominant schemas available to them for understanding the role that governments, markets, and civil society should play in the development of society and the provision of social services—that is, they draw on their home nation's development imaginary. In this chapter, I will investigate Japan's development imaginary and its distinctive narrative about how to solve the problems of underdevelopment. To describe the Japanese development imaginary, I introduce Sokho. Sohko works in a Japanese INGO in Cambodia, and when asked to explain his donors' motivations, he states:

> Do you know about Hiroshima and the atomic bomb dropped there? But, now, Hiroshima is rebuilt and a great city. They [the donors] are comparing their experience of Hiroshima to [Cambodia's experience] after Pol Pot…Phnom Penh can improve in this same way. That is why they support this organization.

As we will see below, like Sokho's donor's comparison of Hiroshima and Phnom Penh, the Japanese development imaginary presents an alternative vision to that of the U.S. imaginary. It includes new interpretations of global norms and a regional discourse in which Japan is an Asian leader. In this chapter, I will investigate the history of the Japanese development imaginary, analyze its assumptions about the state, market, and civil society, and then, assess how this imaginary impacts the construction of women's health activities in Tokyo.

Origins of the Japanese Development Imaginary

As discussed in the previous chapter, national development imaginaries are dominant schema that selectively draw from a nation's development history, which are then applied by development practitioners as they construct aid programs for recipient nations. In the section below, I flesh out the Japanese development imaginary by examining the history of nonprofits in relation to the state and market in Japan as well as foreign aid and INGOs in the country.

Nonprofit History in Japan

The non-profit sector is a relatively new phenomenon in Japan as nonprofits did not arise in any significant number until the 1980s. Nevertheless, historically Japanese civil society existed in other organizational forms in relation to the state and market (Ikegami 2005; Tsujinaka 2010). For instance, Ikegami (2005) argues that during the Tokugawa period, citizens in aesthetic communities, such as artists and poets, played an important role in the development of the modern Japanese state. Furthermore, between 1870 and the late 1880s, there was a movement for democracy in Japan, the Movement for Freedom and People's Civil Rights. An estimated two thousand citizen associations were formed at this time. These include groups like agricultural associations, chambers of commerce, business associations, and industrial associations. Finally, in the Taisho-Showa Democracy from 1918 to 1937, a number of labor unions and social movements were established. However, in the 1930s, the civil society space in Japan shrank drastically and most Japanese citizen associations were absorbed into war mobilization efforts, shut down, or integrated into state-corporatist structures (Tsujinaka 2010).

The limited number of nonprofits in Japan prior to the 1980s is typically attributed to Japan's strong 'developmental state.' This state was characterized by the 'Iron Triangle' or a tight collation of ruling party, corporations, and powerful bureaucracy, specifically, the Ministry of International Trade and Industry (MITI). This coalition, with the capacity for long term economic planning, dedicated itself to Japan's rapid industrialization. It left little space for interest groups to be heard by the government or participate in the market (Hirata 2002; Reimann 2010).

There were a small number of nonprofit organizations in Japan before the 1980s, particularly those sponsored by Christian groups. Japan Overseas Christian Medical Cooperative Services (JOCS) was founded in 1938 and largely provided medical aid to China (JICA 2006). Yet, while Christianity played an essential role in the development of nonprofits in the U.S., this is not true in Japan. Christians make up less than 1 percent of the population in Japan (Ipgrave 2016). Moreover, before the 1998 Nonprofit Organization (NPO) law, Japanese regulatory structures made it very difficult to register as a 'public interest' organization. The process for approval was lengthy, non-transparent, required a 'sound financial base' of up to 3 million USD, and the ministries that monitored non-profits could revoke legal status at any time. Thus, until

the late 1990s, Japan had a restricted and limited non-profit sector, compared to other industrialized democracies (Pekkanen 2006; Reiman 2010).

Economic decline during the 1980s and 90s weakened faith in Japan's centralized state and the Iron Triangle. To promote rapid economic development, throughout the 1960s and 70s, the Japanese government transferred economic resources from more profitable sectors, like export-oriented manufacturing sectors, to less profitable sectors (Choi 2012). But, in the 1980s, Japan faced international pressure (such as the Plaza Accord) and domestic demands to liberalize its economy. Strong export firms began to depart the country in order to cut costs and weaker firms suffered without state protection. Also, in the 1980s, Japan saw real estate and stock market bubbles and, then, a subsequent crash in the early 1990s, leading to the period of economic recession often called Japan's 'lost decade.'

This economic downturn, rising fiscal deficit, and several political corruption scandals sowed seeds of doubt in the developmental state (Hirata 2002). Not coincidentally, in 1993, the Liberal Democratic Party (LDP) lost its majority in the National Diet, Japan's bicameral legislature, for the first time since 1955. Japan also experienced other decentralizing political changes, such as an increase in the number of policies created by the Diet, instead of bureaucracies (Pekkanen 2000). The decline in a centralized Japanese state provided the political opportunity for nonprofit interest groups to be heard.

Furthermore, in 1995, Japan confronted the Great Hanshin-Awaji Earthquake, which acted as a further catalyst for the nonprofit sector (Osborne 2003). The government was slow to act in response to this crisis but volunteer groups rushed to help. The work of relief organizations in response to the earthquake was highly publicized (Pekkanen 2000; Yamashita 2012). Public attention to the work of voluntary groups internationally (discussed in the next section) and domestically in response to the earthquake served to highlight the importance of the nonprofit sector to the Japanese public.

Thus, in 1998, the Diet passed a new NPO law, which liberalized the conditions under which voluntary organizations could register as NPOs and simplified the registration process, although tax-exempt status remained difficult to attain. After this, the number of registered NPOs in Japan proliferated (Pekkanen 2004). In 2006, the non-profit law was updated again, this time further simplifying registration (Reimann 2010). By 2015, there were 50,273 nonprofit

corporations registered in Japan (NPO Center 2015). However, the history of the nonprofit sector in Japan is also deeply intertwined with the development of international nonprofits or INGOs.

Japanese Foreign Aid & INGOs[8]

After WWII, U.S. forces occupied Japan from 1945 to 1952. Due to Cold War politics, as the occupation neared its end, the U.S. saw Japan as an ally to promote economic development and democracy in Asia. U.S. leaders encouraged Prime Minister Yoshida Shigeru to enact this role by becoming an Asian economic leader and considering rearmament. After the 1951 San Francisco Peace Treaty, Prime Minister Shigeru embraced capitalist development (although not re-militarization) (Shinichi 2018). With the signing of the treaty, Japan re-entered the international community and sought to establish diplomatic and economic relations with other nations, particularly Asian nations. Beginning in the mid-1950s, Japan paid reparations to four countries in Southeast Asia—Myanmar, the Philippines, Indonesia, and Vietnam. Soon after, Japan began to offer loans, small grants, and technical assistance to numerous Southeast Asian nations (JICA 2013; Er 2013). Aid to Southeast Asia helped Japan to rehabilitate its image in the region and promote Japanese foreign investment (Higuchi 2013). Historically, Japanese ODA to a country has typically been accompanied by increased trade and investment (Tonami 2017).

Throughout the 1960s and 70s, as Japan's economy developed rapidly, its foreign aid to and investments in Southeast Asia continued to grow. Yet, in the late 1970s and early 1980s, the international community began to critique Japanese ODA. On the international scene, as discussed in the previous chapter, in the mid-1980s, there was growing global consensus that state-lead development or Keynesian economics was a failure and neoliberal economics became the dominant development model. INGO aid was seen, and continues to be seen, as a non-state and 'participatory' alternative to providing direct funding to developing nations. The UN and the OECD's Development Assistance Committee embraced INGOs, encouraging developed states to channel foreign aid funding to these organizations. INGO networking and advocacy continued to grow as NGO practitioners were provided with more opportunities for funding and cooperation. By the late 1980s and into the 1990s, there was also rising support for the need for 'soft aid' addressing issues like poverty and education (Keck and Sikkink 1999; Reimann 2010).

[8]Major developments took place in the Japanese INGO sector in the 1980s and 90s. For this reason, this section includes some data from three interviewees who worked in NGOs during those decades.

Due to these changing norms, Japanese foreign aid began to face criticism from the international community for its strong emphasis on loans, infrastructure, and technical assistance and limited support for "soft" aid. In 1980, Japan offered no funding to INGOs. This was in contrast to increased amounts of support INGOs were starting to see in other developed nations as a result of changing global norms. By 1985, the OECD's Developmental Assistance Committee's annual review of ODA from OECD nations included a special sub-section on INGOs, which highlighted Japan's low levels of support (Reimann 2010).

Pressure from the international community contributed to the increasing number of funding opportunities for NGOs in Japan. INGOs also began playing a more important role in Japanese foreign aid due to domestic factors (Reimann 2010). In the 1980s, "the Indochina refugee crisis" was highly publicized in Japan. Japanese citizens were deeply concerned by the humanitarian crisis taking place in Cambodia, including civil war and the growing number of Cambodian refugees in camps on the Thai-Cambodia boarder. Numerous voluntary groups emerged in Japan to care for refugees in Thailand and Cambodia (Hirata, 2004). One interviewee who works for an INGO founded in 1989, Volunteers United, remembers this time period:

> At that time, many of the older NGOs started… the media covered the Indochina refugee crisis so what's going on in Thailand is really big news in Japan… and at that time the Japanese economy is growing and many younger people become rich and they think we have to do something for the people in the South. How can this happen in Asia? We must help. And, then as the media covers this case… the people who were part of the anti-Vietnamese War movement want to participate too. So, then, many people rushed to go to Thailand. Many people at this time join our voluntary movement, and go to the Thai-border. But, at that time they don't know the meaning of NGO because there are no NGOs in Japan, we just go as a society of people. Even our organization, at that time, we don't know what is NGO…(laughing)… then, we learn from other NGOs there from other countries and start calling ourselves…

Two processes are illustrated by this quote. First, like Japanese foreign aid, international voluntary groups were regionally focused in their conception. Volunteers were particularly motivated to aid Cambodians as fellow 'Asians.' Second, she describes how as early voluntary organizations went abroad to aid refugees, they learned more about what it means to be an INGO from international actors.

Sparked initially by the refugee crisis, the number of INGOs in Japan increased throughout the 1980s and 90s. These organizations began to push for ODA reform domestically, joining the international community in calling for changes to Japan's foreign aid practices. A particularly important player in this movement was a group called Reconsider Aid Citizen's

League (REAL). REAL published reports on the negative impacts of several Japanese ODA projects. REAL was joined in its outspoken criticism by several other INGOs and numerous academics by the late 1980s (Hirata 2002).

Despite the above critiques, throughout the 1980s Japan's ODA budget continued to grow. In 1989, Japan was the world's top ODA donor, providing 20 percent of total global ODA funding (Arase 2005). However, in 1989, Japan's Ministry of Foreign Affairs (MOFA) received cuts to its foreign aid budget due to the economic recession in Japan. Thus, in response to both increasing financial constraints and the above described domestic and international pressures, MOFA began funding INGOs in 1989. MOFA's original "grassroots grants program" was modeled after "USAID's in-country small grant program" (Reimann 2010). Other ministries, such as the Ministry of Posts & Telecommunications, and Japan Environment Corporation also created small INGO grant schemes in the early 1990s.

Aided by increased government funding, INGOs continued to grow in Japan throughout the 1990s, despite the decline in membership fees and donations due to the economic recession (JICA 2006). Additionally, in the 1990s, MOFA began to provide opportunities for NGO collaboration, beginning a quarterly dialogue between MOFA officials and NGO representatives in 1996 (Hirata 2002). Finally, in the early 2000s, MOFA increasingly channeled a portion of its foreign aid budget and duties to JICA. In 2000, JICA launched its Partnership Program, which funds INGOs, universities, and other voluntary organizations, such as professional associations, to implement technical assistance projects in developing nations (Reimann 2010). Thus, while in 1989 there were an estimated 58 international nonprofits in Japan engaged in overseas cooperation, MOFA now estimates there are over 400 (Hirata 2002; MOFA 2013).

The director of Volunteers United, reflects on these changes, stating:

> When I started, I don't think many people knew about NGOs. But, nowadays, when I say where I work or we do some kind of presentation to children, maybe in junior or high school, or even lower, they all basically know what is NGO. Even children! So, the understanding of people has changed a lot in these 30 years.

Public awareness about NGOs in Japan has massively increased since the 1990s, as have funding opportunities. Nevertheless, levels of funding for INGOs remains modest as a percentage of total aid, making up less than 1 percent of the ODA budget in the late 1990s, and approximately 3 percent in the early 2000s (Arase 2004; Reimann 2010). As discussed in the next section, these limited funding amounts deeply affect the size of INGOs in Japan.

Doing Development in Tokyo

The history of Japanese INGOs tells us how the current regulatory policies, funding structures, and INGO characteristics in Japan came to be and provides the foundation for the Japanese development imaginary. In this section, I will discuss the funding and regulatory characteristics of the Japanese development sector and then sketch out the Japanese development imaginary. The majority of the information provided below comes from my INGO interviewees and observations in the development sector but I do utilize secondary sources to provide statistics and comparative information about the regulatory and funding environment. Seven INGOs in my sample are health-focused INGOs; seven are general INGOs with health education activities; one is a OBGYN professional organization funded by JICA to implement a project in Cambodia; and, one is an agricultural INGO that conducts health trainings on nutrition (including maternal and child nutrition). Finally, as noted in the previous chapter, the material characteristics of the development sector and the development imaginary are mutually reinforcing. For instance, the primacy of the developmental state in the Japanese development imaginary is part of the reason why JICA's INGO sector funding is much more limited compared to the resources it provides directly to recipient state governments.

Japanese Donor & Development Sector Characteristics

Japanese INGOs gain the majority of their funds from the Japanese government, Japanese corporations, and Japanese people. All but three INGOs in my sample have current funding from the Japanese government and all but one had previously acquired funding from MOFA or JICA.[9] Two organizations have grants from multilateral agencies, such as the UN. This is in contrast to INGOs in Washington D.C., where all but one INGO in my sample had received multilateral funding at some point. Three Japanese INGOs in my sample are funded by religious groups, one by Christian groups and the other two by Buddhist organizations. Finally, one organization is a social enterprise, funding 50 percent of its activities through the sale of merchandise produced by beneficiaries.

Japanese INGOs are considerably smaller than U.S. organizations (Pekkanen 2004). This pattern is in large part due to Japan's comparatively limited funding market and smaller size of

[9] One organization in my sample was a relief organization and received funds from Japan Platform, MOFA's relief funding, which is known to be more flexible and provide funds for emergency situations. However, most relief funding was not directed towards SE Asia at the time of this research.

government grants (Reimann 2010). There are large international organizations with offices in Japan, like World Vision or Amnesty International, but these organizations receive the majority of their funding from non-Japanese sources. Due to their size, Japanese INGOs are more limited in their international reach. Studies show that while all registered INGOs are active internationally, only 50 percent maintain permanent country offices outside of Japan (Stroup and Murdie 2012). In my sample, only three Japanese INGOs had multiple programs in 8 or more countries. Two maintained distinct activities in 5 or more countries. The majority, 10 organizations, worked on projects in 1-3 developing nations. Because I examined organizations that had or previously had bilateral funding (except one), all INGOs interviewed had enough financial support to maintain at least one permanent office abroad, meaning these organizations are financially privileged Japanese INGOs.

The majority of JICA or MOFA funding is directed towards bilateral ODA or what interviewees call "government-to-government" assistance (Arase 2005; Higuchi 2013; Kato 2013). Historically, in contrast to USAID, JICA and MOFA are known to be relatively autonomous from the Diet (Arase 2004). JICA and MOFA both maintain INGO partnership programs. The programs provide grants for Japanese INGOs to implement international development activities. One MOFA interviewee reports his organization spent 5 billion yen (45 million USD) to support 106 different INGO projects in 2018. He explains that the majority of these projects were carried out in Asia due to the "historical background" of Japanese INGOs "working in Asian countries." He shows me data illustrating that 57 percent of all projects were carried out in the Asian region, of which 20 percent took place in Cambodia.

Unlike USAID, which funds INGOs from all over the world, only Japanese organizations can receive funding from JICA. When asked why this is the case, one bilateral agency interviewee explains,

> I think it's that Japanese ODA has to be more…nationalistic…they think it needs to be from Japanese people to local people. So, these Japanese people have to do the aid, that is the way of thinking. That we… of course, we implement this program by the taxes of Japanese people so we only open this program to Japanese NGOs….There is a strong belief that ODA has to benefit Japanese at the same time, that is the way of thinking. But, not only benefit the NGOs, it's kind of like a face showing, like Japanese people go and do something so the people of that country understand Japanese people and their way, in a good way.

Furthermore, I did not encounter a Japanese INGO working to implement a project in partnership with another INGO during my time in Tokyo. However, to access funds from the JICA Partnership Program, INGOs compete with academic and professional groups in Japan.[10]

Teams of academic researchers are made up of a number of professors and students who propose to implement a development project abroad. For instance, one interviewee is a professor, who previously applied with an academic team to implement a program in Cambodia. The team felt they had 'knowledge and research but they could not give back to local farmers.' His group implemented a sustainable farming project, teaching farmers to use organic seeds. After this project, he later founded an INGO that works in the agriculture and health sectors. Professional associations can also apply, proposing to implement development projects using their professional expertise. For instance, one interviewee is the director of Japan's national OBGYN association. With JICA funding, her association collaborated with doctors from the Ministry of Health in Cambodia to improve gynecological and obstetric services in the country.

JICA has three types of loans. First, community loans for newer organizations provide up to ten million yen in total (approximately 91,000 USD) for three years, second, support loans total sixty million yen in total (approximately 500,000 USD) for a maximum three years, and finally, the largest grant, partner loans, are for 100 million yen in total (approximately 1 million USD) for up to five years. Grant making is done by prefecture. In contrast to USAID, which only maintains a headquarters office in D.C., there is a JICA office in each prefecture and each has a partnership budget. Different prefectures recommend international partners for grants from their own area. More remote prefectures may have more university applications and fewer INGOs in their area, thus giving out more university grants. Then, grants are approved by JICA Tokyo and dispersed through JICA's overseas offices, which it maintains in the regions where it provides aid (JICA has 50 overseas offices in total).

In Tokyo, JICA staff typically meet with INGOs that want to apply for funding before the proposal deadline to help them create a project design matrix, budget, and project plans. However, JICA and MOFA do not call for specific projects from INGOs. JICA must follow MOFA's priority areas, and MOFA dictates foreign aid priority areas in each country, such as health or agriculture. INGOs are encouraged to let these sectors guide their work but neither

[10] JICA offers a separate, larger grant for academics to conduct development-related research abroad (up to 5 billion yen or 45 million USD).

JICA or MOFA put specifications on the types of projects INGOs propose within these broad priority areas. This diverges from USAID's calls for application, which typically include detailed descriptions of project activities, determined in USAID missions. In Japan, this open funding structure and fewer of the kinds of rapid shifts that reflect changing Congressional priorities for USAID, make it easier for INGOs to implement long-term projects. Ten Japanese INGOs in my sample, including Health Services Asia (HSA), had worked on the same project for over 10 years, often switching between corporate, JICA, and MOFA funding streams to continue their work.

When it comes to project planning, JICA and USAID funded INGOs use similar project design paperwork, detailing project outcomes in logframes and then, creating detailed activity workplans. Since JICA funded projects are typically smaller, logframes and workplans are somewhat shorter but otherwise formatted similarly. For monitoring and evaluation (M&E), JICA typically requires a baseline and endline survey documenting quantifiable outcomes, quarterly reports, and conducts internal evaluations at the end of programs. INGO practitioners in Tokyo inform me in the past ten years, JICA and MOFA's reporting requirements have continuously become more stringent and numerous. JICA evaluates projects at their completion on qualitative and quantitative criteria or the "value judgment based five evaluation criteria."[11] (JICA 2007).

[11] (2) Value Judgment Based on Five Evaluation Criteria
Evaluation is undertaken for the purpose of making a value judgment based on the achievement of results. JICA adopted Five Evaluation Criteria for conducting an evaluation (mainly project evaluation), which was proposed by the Development Assistance Committee (DAC) at the Organization for Economic Cooperation and Development (OECD) in 1991. These five criteria, as shown below, are meant to be used for evaluating development assistance activities from a comprehensive range of criteria. (Refer to 2-2-1 for detailed explanation)
i) Relevance
A criterion for considering the validity and necessity of a project regarding whether the expected effects of a project (or project purpose and overall goal) meet with the needs of target beneficiaries; whether a project intervention is appropriate as a solution for problems concerned; whether the contents of a project is consistent with policies; whether project strategies and approaches are relevant, and whether a project is justified to be implemented with public funds of ODA.
ii) Effectiveness
A criterion for considering whether the implementation of project has benefited (or will benefit) the intended beneficiaries or the target society.
iii) Efficiency
A criterion for considering how economic resource/inputs are converted to results. The main focus is on the relationship between project cost and effects.
iv) Impact
A criterion for considering the effects of the project with an eye on the longer term effects including direct or indirect, positive or negative, intended or unintended.
v) Sustainability

It will come as no surprise, due to the U.S. development sector's emphasis on professionalization, that USAID surpasses JICA in its number of M&E requirements. HSA has three quantitative indicators measuring improvement in maternal and child health outcomes via child nutrition, mother's nutrition, and visits to health center. GFA's M&E plan maintained 30 different quantitative outcomes to be measured including the above outcomes as well as more detailed outputs such as counting numbers of women and children at trainings. In part, this is related to size of projects, larger projects include a larger number of activities to be measured. Local NGOs, sub-contracted to implement just one or two activities by INGOs with USAID funding are comparable in project size to many Japanese NGOs. Thus, we might compare the work of HSA to GFA's local NGO subgrantee, Cambodian Development Society (CDS). In doing so, we find USAID emphasizes quantitative measurement more readily, and CDS has ten quantitative indicators compared to HSA's three.

All but one INGO in my Tokyo sample maintained corporate funding. It is common practice among Japanese INGOs to have leadership who are retired from large Japanese corporations to network with Japanese companies and build relationships to receive corporate funding. Also, Japanese practitioners often cooperate with Japanese companies by conducting workshops with company employees and their families. Workshops typically include a discussion of the INGO's work and often an activity, such as making picture books in Khmer or stuffed bunnies to provide to beneficiaries. Finally, INGOs do sometimes apply formally to company CSR grants when available.

The Japanese INGOs in my sample vary in how much funding is received from companies. All INGOs have at least two corporate donors and most report receiving around 15-20 percent of funding from corporations. Two INGOs are company foundations, with over half their funding provided by the company with which they are associated. The interviewee at one company INGO, Learn & Grow, explains that his company's founder realized in the late 1990s that "he sends a lot of money to the INGO but… all the money was used to run the organizations' headquarters, not for the INGO work." So, the founder decided to "start his own INGO and send all the profit directly to the site of INGO work." Company INGO interviewees report different levels of autonomy from their corporations. At Learn & Grow, the corporate

A criterion for considering whether produced effects continue after the termination of the assistance.

CEO determines program activities. However, the other company INGO, Mother's Heart, is run by the wife of a corporate executive and she reports the corporation has little to do with programming.

Interviewees in INGOs that are not company INGOs report that corporate funding amounts are typically smaller than bilateral grants. Corporate funding is often used alongside multiple funding sources or to fill in time periods between government grants. However, corporate funding is also seen as more flexible by all organizations in my sample. When asked about corporate funding, one program manager for a general development and relief organization, Japan Aid, explains,

> I think the government funding, the amount is much bigger than the corporate… so we can do like a 3 year project or something.. but for the corporate or the private sector funding from the company…it is much smaller in terms of the amount. But, it depends on the company…but I think for many companies, it is more flexible than the government. So, we can use it to do what we need and fill in gaps. Like if the government won't fund a community event, we can use the corporate funding to do that.

All Japanese INGOs in my sample also try to encourage individual sponsors. Sponsors can be gathered through the above discussed corporate events, where individual company workers who participate can sign up to provide monthly donations. Additionally, INGOs try to gain sponsors from the general public through numerous types of public outreach, such as lectures describing the INGO programs. Finally, most INGOs host study tours where university students, professionals in the sector (such as health experts for a health INGO), corporate donors, or sometimes the general public can go to visit their INGO in a recipient nation for a fee.

Finally, only three Japanese organizations in my sample gain funding from foundations or UN agencies. All are larger organizations that work in eight or more countries. When I ask how they access this funding, one INGO interviewee at Japan Aid explains that staff write proposals for these funding opportunities. Sometimes, staff at her INGO do this on their own but other times, "the Japanese government gives money to the UN in an area, like refugees, and the Japanese embassy was asked by the government to help get Japanese INGOs to do activities using that international fund." When I ask her why she thinks other Japanese INGOs have limited multilateral funding, she provides two reasons. First, she thinks organizations with international funding are more likely to work in emergency and relief in areas like Africa or the Middle East, while Japanese aid more often goes to Asia.

Second, she reports many Japanese INGOs are "small INGOs so it is more difficult to have the capacity to write the proposal and everything in English." Thus, a history of limited political opportunities, restrictive regulatory structures, limited transnational networking, and narrow funding opportunities mean Japanese INGOs remain smaller relative to their U.S. counterparts. This restricts many Japanese INGOs' ability to compete with large Western INGOs in the market for international grants. Only two Japanese INGOs in my sample report networking with INGOs from another nation. Limited international funding and international connections insulates Japanese INGOs, setting the stage for the distinctive Japanese development imaginary described below.

The Japanese Development Imaginary

As discussed in the previous chapter, development imaginaries are selective histories – dominant schemas available that draw on some aspects of how a nation achieved its developed status, while ignoring others. Japan's development imaginary highlights some parts of the Japan's development trajectory, like the developmental state, and ignores others, such as the U.S. occupation, or the so-called lost decade. For instance, JICA's 2005 report, "Japan's Experiences in Public Health and Medical Systems: Towards Improving Public Health and Medical Systems in Developing Countries" selectively reviews Japan's maternal and child health development experience since the early 1800s, but contains no references to the U.S. occupation.

Practitioners in Tokyo, embedded in Japan's development imaginary, construct programs and decide the types of activities to support in developing nations. While U.S.-based practitioners more often draw on global norms to formally justify aid, Japanese practitioners are more forthright about exporting their nation's development experience. JICA's formal reports state that Japanese aid helps other nations by "showing them the developmental experience of Japan" (JICA 2013). Below, I analyze the Japanese development imaginary, which, compared to the U.S. development imaginary discussed in the previous chapter, contains very different understandings of the role that state, market, and civil society play in societal development.

The State.

In the Japanese development imaginary, the state is the primary agent of development. With strong state leadership, Japan developed rapidly in the 1950s and 60s. Japan uses foreign aid to promote its own rapid development as an example for developing nations to follow. Studies have documented the importance of the developmental state in Japanese foreign aid in numerous recipient nations (Arase 2004; Tonami 2018).

JICA interviewees report that it is 'strongly recommended' that all INGO grantees identify a government ministry partner in developing countries. Twelve of the INGOs I interview in Tokyo implement project activities through a government partner organization and all INGOs report close cooperation with recipient nations. Japanese practitioners often express the belief that beneficiaries deserve a strong state. One worker at a health INGO, Together International, states, "the Japanese government…They provide needed services to Japanese people, like medical services, education all of it. So, in the past, we don't need to think about those. I think the people in the developing countries deserve to have those services too." In the Japanese context, it is assumed the state will implement basic services, and therefore, is a natural partner in development programs. Government partners are considered essential to project sustainability.

INGO activities support recipient states by working with state officials to write new national policies or supporting recipient state partners to implement government policies. For instance, the program manager at Together International explains:

> We wanted to work with the communities on basic health, so of course, improving the public health center is the first priority, as it is the primary health center for the community, through the government. So, that was why we decided it was a priority to support…we work with provincial and district level staff to implement health center monitoring policies in Maternal and Child Health.

As described in the Introduction, Health Services Asia (HSA) trains provincial health officials to implement maternal and child health policies. In the project matrix provided to JICA, HSA defines project 'direct beneficiaries' to be government staff and 'indirect beneficiaries' as mothers and children. In Japan's NGO sector, the specter of Japan's own developmental state looms large and project activities heavily stress aid to developing countries so that they can become strong states in their own right. In the Japanese development imaginary, it is not the market but the state that is the key driver of development.

The emphasis on Japan's strong state-led development also comes intertwined with the regional rhetoric discussed at the beginning of this chapter. Japan was the first Asian nation to achieve developed nation status, and, due to this, many interviewees espouse the idea that it should act as a regional leader. Japan has a history of employing foreign aid to enhance its position in Asia. It is the oldest foreign aid donor in the East Asian region and both South Korea and China have benefited from Japanese aid and learned from Japan's foreign aid model

(Stallings and Kim 2017). One interviewee from a general INGO, Child Aid Japan, explains education project in Cambodia, which is funded by JICA:

> We do an early education project in Cambodia. So, [we] partner with the Ministry of Education and we ask the national staff and the provincial directors to be a participant in the training with our education expert from Japan… we do a lot of trainings for them, and sometimes inviting them to come to Japan to do more training in Japan because Japan is known for its high-level education system in Asia. And then, we ask them to come with us for monitoring to project sites, like the schools in the provinces and to do the training for the teachers to learn to implement the policy themselves. And, we also helped the Ministry create the guidelines for early education projects in Cambodia, we show them the way, and how to follow the guidelines of Japan and our past success…the goal is that in the future the Ministry of Education can implement early childhood education themselves.

Here, we can see multiple aspects of the Japanese imaginary -- the emphasis on strengthening the Ministry of Education, a regional comparison to education in Asia, and the idea of Japan as a regional leader.

As discussed above, many Japanese INGOs have Asia-centric origin stories, with a large number originating at the Thai-Cambodia border. An HSA headquarter interviewee explains "Many NGOs that started in that area…they started because they wanted to help refugees in Indochinese countries. They hear about it and they feel like they are from Asia, it is much closer to Japan, we can't let other Asians suffer like that." Many Japanese NGO interviewees espouse a narrative about the need for Asian nations to rise together and support one another, like the interviewee at the beginning of this chapter who equates Hiroshima after the atomic bomb to Phnom Penh after the Khmer Rouge. Accompanying regional rhetoric, there is also a strong belief that because Japanese culture is 'closer' to Khmer culture, Japanese INGO interventions will be better suited than those of Western INGOs to the cultural context in South and Southeast Asia.

Relatedly, Japanese INGOs often implement cultural exchange activities. Half the INGOs in my Tokyo sample engage in cultural exchange activities of some kind, with INGOs that implement education activities being far more likely to do so. These activities include training beneficiary students in Judo lessons, Japanese language, manga, and traditional Japanese music. When asked why Japanese INGOs engage in cultural exchange, one foundation practitioner provides the following opinion:

> I guess the Japanese people are kind of proud of their culture, and even though they don't like to show it off or anything, because we lived in an island, and we are a rather homogeneous population, and because there are people who are kind of interested in just Japan, in terms of whether it's judo or the math or some certain topic related to Japan, I guess Japan thought, "Hey, maybe we can just go to other countries to introduce the Japanese way of certain things.

Often, cultural exchange comes alongside a valuing the 'traditional culture' in the recipient nation as well. For instance, in Cambodia, cultural preservation takes forms such as traditional dress fashion shows featuring traditional Khmer attire and kimonos. The program manager of Child Aid Japan explains her organization values cultural exchange across Asia, preserving the 'cultural history of a people,' 'reminding the next generations,' and 'promoting the value of Asian cultures.' During my time in D.C., I encountered no U.S. INGO engaged in cultural exchange as part of their international development aid or any direct discussion of specifically American cultural practices that should be emulated.

Yet, within this rhetoric of 'Asians helping Asians,' Japan is often positioned as the developed older brother nation. HSA's director, Junko, tells me about a fish we're eating. She explains to me that this particular fish is called 'the Japanese fish' in Khmer because it was supposedly given to the Khmer long ago by a Japanese emperor. She states, "even in that time, the Japanese were helping to improve the health of their smaller neighbor kingdom."
Japan promotes its early development experience as rationale for its position as a leader, which other nations in the region should look up to, alongside a rhetoric of Asian regionalization and promoting Japan-recipient nation cultural exchange.

The Market. While Japanese bilateral aid has been criticized for promoting Japan's economic interests abroad, in Japan, INGOs and the market reside in starkly separate spheres. INGOs in Japan do often maintain corporate donors, but private funders perceive INGOs as small charities, not partners. Due to the absence of market logic in the sector, while there has been an increase in the quality and quantity of monitoring and evaluation, professionalization practices and managerial techniques present in the U.S. development sector are more limited in Japan.

Market rhetoric is also not prevalent in the Japanese INGO sector. Entrepreneurial projects, such as savings groups or small business microfinance, were few and far between. Only one INGO in my sample, Haiku Global, pursued organizational sustainability through the market. This INGO ran a vocational training facility for women, training them in sewing,

weaving, life skills, and in some cases, management. It maintained a small factory making specialty goods, like purses, shirts, and woven mats, which are sold in order to support the organization. The director explained that he came up with the idea to pursue sustainable funding in this way in via interactions with his UN donors. When asked about long-term sustainability, all other INGO interviewees in Tokyo report that project activities will be supported by recipient governments after the funds run out or, two interviewees report that they simply don't know what will happen. This is in contrast to U.S.-based INGOs who see sustainability as coming from the market.

Japanese INGO collaboration with developing states does comes alongside a rhetoric of self-sufficiency, albeit a different one than U.S. market individualism. For example, one U.S. health INGO's program goal is to make Cambodian citizens "informed and self-sufficient healthcare consumers." Comparatively, Japanese INGO staff explicate they do not want to 'make beggars' out of the Cambodian people but, for them, it is the recipient state that must become self-sufficient, instead of individual beneficiaries. And, in doing so, the state must "successfully promote the private sector." One HSA practitioner informs me that his INGO cannot just give the Cambodian state the equipment or provide the services for them because "it will make the local government to rely on us or rely on the project." Challenging scholarly assumptions that INGOs are typically deeply embedded in neoliberal development norms, Japanese INGOs promote state implementation of social services, not market reliance.

Civil Society. The rhetoric around grassroots advocacy and civil society support that we see in D.C. is relatively limited in Japan. I interviewed a college professor, Dr. Ito, who previously worked for Volunteers United (VU) in Cambodia and continues to consult for the organization. She recounts her experience of the 1980s and 1990s. 'The Japanese people were more socially active!' Many NGO volunteers were people who participated in anti-Vietnam war or anti-nuclear advocacy during the 1970s and 80s.

Dr. Ito tells me she thinks that while INGOs have proliferated, there is less interest in promoting civil society in recipient nations or domestically. She provides several reasons for this apathy – an economic slump means people have less money and time to give; the people who lived through the Vietnam and Cold War are aging; the excitement over new incoming global norms and this new type of organization, the INGO, has gone stale; and, there is a lack motivation to critique the Japanese government or recipient governments. INGO interviewees

also report concerns about the possibility they will have trouble accessing JICA or MOFA funding if they speak out against the Japanese government, or that it will be difficult to create the kinds of strong relationships needed with recipient governments if they are critical of them. Additionally, Japanese public opinion is critical of organizations that advocate against the government (Stroup and Murdie 2012).

Any discussion of democracy, civil society, gender equality, or human rights is absent from almost all Japanese NGO interviews I conducted in Tokyo and Phnom Penh. The rhetoric of civil society that is ubiquitous, albeit to different degrees, in U.S. INGOs across all sectors is limited in Tokyo. INGOs addressing human rights concerns are rare, as 4 percent of all Japanese NGOs work in human rights or democracy (Japanese NGOs and SDGs Report 2019). Contributing to this, funding to advocacy organizations is extremely limited in the Japanese context (Reimann 2010). Japanese NGOs are most likely to implement activities in technical sectors. The majority work in education, health, and agriculture (the exception being a large number of environmental NGOs) (JICA 2006). Typically, when I asked other interviewees directly about advocacy or human rights, they told me that their organization did not work on that. However, a few people told me I should talk to the staff at Volunteers United, one of the most well-known human rights organizations in Tokyo.

Volunteers United engages in social advocacy due to its unique history. It was founded in the 1980s by socially active Buddhist groups. It is an outlier INGO in my sample. It was engaged in the criticism of Japanese ODA and the struggle for the NPO law in the 1990s, and thus, maintains contacts with an active network of domestic advocacy groups. It also promotes grassroots mobilization abroad. When I ask VU's director why other NGOs might avoid lobbying the government he states

> At VU, we try to be independent. We have different ideas… like in 2016… the current government pass the law… and Japan can send troops to South Sudan. We think actually, we don't need to join like that… we have non-military support we can do… we are against that… you see so my former president of VU and I were in a big newspaper because we were in front of that demonstration. In front of parliament. And, some staff are afraid… like can we get MOFA funds now? But, actually it's ok! Maybe…it's because we know the UN Mission… but I ask many other NGOs to join and they say they have the same opinion on the South Sudan as VU but they cannot speak out. I think many NGOs are afraid… but for us, civil society is really important… compared to USA and EU, people cannot say openly here…

Another interviewee, from Japan Aid, believes there are few democracy or human rights projects done because Japan does not like to put specifications on 'what democracy should look like in other nations' or 'intervene in other cultures.'

Thus, Japanese INGOs largely do not participate in the civil society promotion in which U.S. and European INGOs typically engage, only one discusses topics like human rights or democracy and none provided funding local NGOs or grassroots groups in recipient nations. However, as the above discussion of aesthetic communities illustrated, civil society in Japan can look different than the traditional nonprofits and charities of the U.S. and Europe (Ikegami 2005). In studying the Japanese INGO sector, we might need to expand our understanding of 'civil society.'

Although scholars vary in the degree to which they consider colleges, universities, and academics traditional civil society actors, it is necessary to consider them in a discussion of civil society and Japan's development imaginary. Many colleges and universities are publicly funded, others are private, but certainly most higher education institutions have private interests related to tuition. However, universities and the academics within them can also play roles traditionally associated with civil society, like educating communities or critiquing government policies. For instance, university actors can raise awareness through public lectures or service learning (Gardinier. 2016).

Specifically, in the Japanese development sector, academics play an important role at home and abroad. Academics were at the forefront of criticizing Japan's ODA policy in the 1980s. At a development conference hosted by JICA to discuss Japan's role in Africa, in a full day workshop, there are seven academic presenters, three government presenters, and just two INGO presenters. In Tokyo, academic visions for international development are held in high esteem. This is in stark contrast to conferences in Washington D.C. where INGO practitioners are considered development professionals in their own right and academics are rarely present. JICA interviewees report that academics often partner with JICA on bilateral ODA projects. INGO interviewees also feel it is important for universities to play a role in raising student awareness about international problems. During my time in Tokyo, I observed several conferences for students on international issues, like the UN's Sustainable Development Goals.

Moreover, academics play a consequential role in recipient contexts. As discussed above, academic groups can gain funding from JICA to implement development projects. Japanese

INGOs also often had academic consultants on their projects in developing countries. Two different practitioners report their organization flies Japanese academics to their program site in recipient countries. One interviewee from Together International explains, "we invite medical professors and experts from Japan to give lectures for provincial hospital staff because they need to know how to evaluate activities and improve their supervision. And, the [Cambodian] staff who really succeed, we invite for training in Japan."

Academics play an important role in advising and shaping INGO programing in Japan and abroad. Thus, while we do not see civil society advocacy through support to local organizations or community-based groups as we do in D.C., academics, as civil society members, play a unique role in the Japanese development sector, critiquing development programming, providing guidance, and raising public awareness.

Finally, while Japanese INGOs largely eschew traditional development norms like human rights and democracy promotion, that does not mean they have no engagement with global development norms. Therefore, before moving to a discussion of how the Japanese imaginary manifests in women's health programming, we must examine the Japanese development imaginary vis-à-vis norms of global development.

Multi-Vocal Global Norms. Many critics contend Japan's development assistance agencies only superficially adhere to the OECD's Development Assistance Committees norms while pursuing their own development agenda or that Japan's foreign aid largely follows a Japanese model with a few millennium development goals thrown in (Stallings and Kim 2017). As a participant in the international community, Japan has, at least formally, adopted a number of global norms. Nevertheless, advocacy groups have criticized Japan for its lack of commitment to global norms at home and abroad. Japan formally adopted human rights policies but often acts inconsistently with regard to them. For instance, while Japanese officials play lip service to women's rights, Japan's rape law requires proof of violence or a loss of consciousness that renders the victim unable to resist. This ignores UN Women's recommendation that legal policies define rape as a "lack of freely given consent." (Human Rights Watch 2020).

Yet, I find the rhetoric of the Japanese development sector is more complicated than just superficial engagement with global norms. Japan is an OECD nation and an active UN member. Global governance and foreign aid have historically been important to Japan since it does not participate in international security (Dobson 2016). In comparison to the degree to which the

foreign aid agendas of China and South Korea follow global norms, Japan is considered a centrist. South Korea adheres more strictly to OECD's Development Assistance Committee norms while China, as a non-OECD member, has a unique foreign aid model (Stallings and Kim 2017).

The global norms or developmental ideals Japan encounters in the international arena are not a coherent set of beliefs but vague, and multi-vocal directives, such as "to empower the people of developing nations" (Thorton, Dorlus, and Swindle 2015). Thus, JICA and MOFA officials and INGO practitioners can opt to strategically draw on certain scripts, interpret some norms, and ignore others. Many dominant global norms, such as those discussed above, including civil society, democracy, gender equality, and human rights, are, more often than not, simply ignored by INGO interviewees. More neutral global norms, such as Sustainable Development Goals (SDGs) three and four, health and wellbeing and quality education, are taken up wholeheartedly. The SDGs are often posted on a wall in INGOs offices and interviewees gladly tell you their organization works to achieve these goals.

However, some global norms are re-interpreted through the Japanese development imaginary, taking on new meanings. For instance, 'empowerment' is employed to discuss building the capacity of state officials to implement government policies. 'Advocacy' is used by one interviewee to discuss the long-term, friendships NGO staff built with developing country government officials to 'gently' and 'quietly' convince them of the strength of shifting their national policy to match 'the Japanese way of doing education.'

Perhaps the most prominent of these re-interpreted terms is kusanone or grassroots. I first encountered it before coming to Tokyo, at HSA's offices in Cambodia, when observing new staff orientation. Boran, the Khmer program director, put up a powerpoint. After detailing HSA's mission and history, he describes the current project, pulling up a slide with one bullet point stating 'HSA's devotion to working on the grassroots level,' next to a model of the different decentralized levels of the Cambodian government. I am confused; as an American, the term 'grassroots' brings to mind third sector, or civil society, advocacy. Yet, without missing a beat, Boran explains that to work on the grassroots level means cooperation with multiple sub-national government partners. 'Grassroots' partners are considered non-national officials, from the province, district, and commune levels.

In Tokyo, I discover this understanding of the term, 'grassroots' is widespread. Japanese INGO staff often tell me that their organization works at the grassroots level, before proceeding to describe which local-level government officials they partner with. A program manager, at Together International, states, "yes, we work at the grassroots level, with the district officials, commune leaders, and government village volunteers." Moreover, a bilateral agency interviewee informs me that JICA's INGO partnership program is called the kusanone (Japanese word for grassroots) program, meaning INGOs engage in "grassroots technical cooperation with local government staff and stakeholders." In Japan, 'grassroots' is defined quite differently than in the U.S. context.

This type of interpretation and selection of global norms is less evident in the U.S. case, although it does take place. For instance, many U.S. practitioners argue they engage in grassroots advocacy, and highlight that their organization creates community support groups and includes marginalized populations, such as disabled women. But, U.S. INGO staff often ignore other activities that are included in the meaning of grassroots advocacy which are pursued by INGOs from many European nations, like social movement building. Nevertheless, as discussed in the previous chapter, the U.S. played a prominent role in the historical construction of development norms. Thus, U.S. more closely approximates 'global norms' because these norms are to some degree a reflection of US hegemony, making reinterpretation less necessary.

In conclusion, in the Japanese development imaginary, the developmental state is the primary driver of development. The market is assumed to be coordinated via the state and civil society includes an academic community of experts. Moreover, global norms, such as grassroots advocacy, are reinterpreted through the Japanese development imaginary.

Modern Asian Mothers: Women's Health in the Japanese Context

In this section, I will investigate how the Japanese development imaginary manifests with regard to concrete practices in women's health. Before doing so, I will briefly examine the history of gender and health policies in Japan, which inform the development imaginary when it comes to understandings of how to advance women's health in other nations.

Gender & Family Policy in Japan

Japan's current gender and family policies were influenced by the U.S. occupation of Japan after WWII. American troops understood Japanese gender relations to be "backwards" in

comparison to "progressive Western" gender relations. During the occupation, the Equal Rights Amendment was written into the New Japanese Constitution and Japanese women were granted suffrage. American female soldiers also worked in small education centers to 'educate' backwards Japanese women around the country (Koikari 1999).

After the occupation, between 1958 and 1961, Japan began to develop its welfare state, introducing universal pensions and health insurance for citizens. After WWII, the Japanese government emphasized the goal of full employment for Japanese men to raise living standards (Choi 2012). This focus on employment lead to a social welfare system which depended on companies providing a family wage and women to provide familial care (Tanaka 2018). Japan's welfare state development was strongly undergirded by cultural values. For instance, the "Nihonjinron discourses," a well-known compilation of texts focused on Japanese cultural and national identity, became popular after WWII. "Positing the strength of 'traditional' family and community networks [the texts] have long undergirded policy and public discourse framings of social welfare systems" (Goldfarb 2016: 152).

Throughout the 1970s and 1980s, there were tax incentives provided for families with stay-at-home wives and the availability of non-family child or elder care was very limited. Additionally, in 1971, Japan established the Children's Allowance law. The law provided universal child allowances to low- and middle-income families in Japan, increasing stipends with number of children. However, in 1973, after Japan faced economic hardship due to the international oil crisis, its welfare state development was stunted (Takegawa 2009). By the late 1970s, the 'Japanese style welfare society' rhetoric arose, promoting self-help, familial reliance, and a moderate degree of state intervention (Choi 2012; Takegawa 2010).

Gender and family in contemporary Japan are shaped by the legacy of this 'familial' welfare state (Ochiai 2014; Ogasawara 1998; Peng 2012; Whitley 2013). However, in light of low fertility rates, by the 1980s Japan began to pass laws to promote family-work balance to increase female labor force participation. It passed the Equal Employment Opportunity Act in 1985, and during the 1990s expanded the provision of child care and parental leave (My 2013; Estevez-Abe 2014; Peng 2012). For instance, the Child Care and Family Care Leave Act passed in 1991 (recently updated to expand leave time in 2017), promotes employee leave to care for family and children (Hirao 2004; Roebuck 2017). Additionally, in 1999, the Basic Law for Gender-Equal Society was passed, which aimed to create an equal or "gender-free" society,

though it has faced conservative backlash (Yamaguchi 2014). Finally, the Child Welfare law required municipal governments to provide affordable daycare centers for 8 hours a day (National Institute of Population and Social Security Research 2014).

Currently, due to the numerous policies put in place to promote work-life balance and decreases in men's earnings, gendered work norms are changing, although a strong gendered division of labor remains. The male breadwinner model remains embedded in workplace culture (Boling 2015; Ochiai 2014). In the Japanese labor market, firms traditionally provide male breadwinners with long-term jobs. In contrast, women are often relegated to temporary or lower paying employment opportunities, it is assumed their income is supplemental to a male partner's or they will quit the job after childbirth (Hirao 2004; Ogasawara, 1998; Peng 2012; Schoppa 2006). Employer expectations of full-time employees include very long work hours, with 60 percent of employees working more than ten hours a day. In 2016, approximately 75 percent of Japanese women ages 25-54 worked full time, up from 65 percent in 2000. However, approximately 33 percent held part-time jobs and less than 10 percent hold managerial positions (compared to 30 percent of women holding managerial positions in the U.S.) (Shambaugh, Nunn, and Portman 2017).

Japanese women are left with two options: "emulate workplace masculinity or opt out" (Neomoto 2012; 512). With such demanding norms, there is an increasing trend in which many women choose not to have children in order to continue their full-time career (Schoppa 2006). When women do decide to have children, reconciling work and childcare is largely seen as a problem for women to solve (Hirao 2004). Among employed women, 67 percent quit working, at least temporarily, after childbirth (Neomoto 2012). Strong norms hold it is best if mothers stay home with young children, or what is called the "myth of the three-year-old." Privatized education and extra educational services like cram schools also make having children increasingly expensive in Japan. Many Japanese women feel ambivalent about having children due to the difficulties of work-family balance (Hirao 2004).

Finally, the breadwinner model means that single mothers in Japan, while they only make up 12 percent of the population, find it very difficult to achieve economic stability due to challenges in combining work and childcare. Single mothers are typically forced to depend on public assistance (Ezawa 2016). Despite many Japanese women's continuing difficulties combing work and motherhood, Japanese government's anxiety about declining population

growth manifest in an emphasis on the value of motherhood. Thus, as we will see below, it invests in high quality maternal and child health services.

Health Policy in Japan

Despite limited welfare state spending more generally, in Japan, healthcare has been an area of high public expenditure. In 1937, the Public Health Center Law was enacted, establishing numerous national health centers and increasing provisions for public nurses (JICA 2005). During WWII, Japan was under military rule and at this time, health institutions were created to address infectious disease and improve maternal and child health in order to increase the population eligible for military service in the future (JICA 2005; Miyaji and Lock 1994). But it was not until the late 1950s that Japan gained the financial resources and political will necessary to begin constructing its current public healthcare system. After WWII, Japan faced high levels of infectious disease and a high infant mortality rate. Through strong public health outreach programming, Japan succeeded in eradicating diseases and improving the morality rate incredibly quickly in the 1950s and 60s (JICA 2005). Japan implemented universal health coverage for all Japanese citizens starting in 1961 (Sakamoto, et. al. 2018). This state-lead healthcare system continues today.

State support for healthcare is high and no for-profit entity can own a hospital. Healthcare costs are strictly regulated by the Japanese government, making it relatively affordable to all citizens. Japanese citizens are required to pay for 30 percent of care under the universal coverage. While private coverage is maintained by many Japanese citizens, it plays a supplemental role. The national government engages in centralized healthcare planning, regulates insurance, healthcare providers, and controls the cost of drugs. It also allocates funds to prefectures for the implementation of national policies and healthcare delivery (Matsuda 2016). Contemporary Japan does face healthcare challenges, such as the need to upgrade its public health system, particularly to care for its increasingly aging population. Nevertheless, Japanese healthcare is considered one of the best systems in the world and Japan has one of the longest life expectancies in comparison to other developed nations (Zhang and Oyama 2015).

Specifically, Japan invests heavily in maternal and child health. Japan's infant and maternal mortality rates (IMR and MMR) are some of the lowest in the world but this was not always the case. In 1947, Japan's IMR was approximately 76 per 1000 live births. By 1980, the IMR in Japan was down to 6.8 per 1000 live births, falling to 1.8 in 2018 (Knoema 2018;

Takeuchi, Sakagami, and Perez 2016). The MMR is similarly low, with 5 deaths for every 100,000 births in 2017 (compared to 23.8 per 100,000 births in the U.S.) (Delblanco, et al. 2019; Knoema 2018). Japan's rapid decrease in its infant and maternal mortality rates is attributed to high government investment, including training and deployment of midwives and nurses, building maternal and child health centers, and dispersal of Japan's Mother and Child Health Handbook (JICA 2005; Takeuchi, Sakagami, and Perez 2016). The handbook, which began to be officially used all over the nation in 1947, provides both educational information to new mothers and record-keeping for maternal and infant health markers (Homei 2006; Takeuchi, Sakagami, and Perez 2016).

Currently, pregnancy in Japan is highly monitored, with 90 percent of women seeking prenatal care before the 20th week of pregnancy and 100 percent giving birth in a medical facility. The government provides free antenatal visits and a reimbursement allowance covering a large percentage of the cost of delivery. In addition to a strong public health system, Japan's maternal and child health indicators are attributed to the high educational level of the population and the fact that the majority of Japanese women birth a limited number of children. Maternal and infant health holds an important place in Japan's vision of its modernization (Homei 2006). Japan prides itself on its rapid improvement of maternal and child health and, as we will see in the next section, it actively works to export its model to the world (Takeuchi, Sakagami, and Perez 2016).

However, the Japanese public health system does not emphasize reproductive health. Through private industry and trade, condoms began to be imported to Japan in the late 1800s. In 1936, Shidzue Kato, a friend of Margaret Sanger, opened her first Birth Control Consultation Center in Tokyo, facing political repression at the time. She continued to fight for access to birth control throughout her life (Kato 1984). Yet, the Japanese government's emphasis on fertility in war time largely thwarted her efforts. The birth control pill was not approved for use in Japan until 1999, making Japan the last developed nation to legalize it (Htun 2013). There is limited availability of medical contraception and a lack of education on contraceptive options. Japanese couples are more likely to rely on condoms, the rhythm method, or withdrawal. In Japan, 80 percent of married women rely on condoms and only 3 percent of women age 16-49 report taking oral contraceptives (Htun 2013; Yoshida, et. al. 2016).

Abortion was legalized in 1948 in Japan during the U.S. Occupation. It was originally legalized under the "Eugenics Protection Law," which is now called the "Maternal Protection Law." Under the law, women can get an abortion if they meet specific criteria such as birth defects, danger to mother, or "economic reasons" with the approval of the physician. Strict social norms dictate marriage is required in order to have children, with only 2 percent of children born to unmarried mothers in Japan (the single motherhood described above is most often due to divorce). With few medical contraceptive options and limited discussion of family planning, abortion is widely used when unmarried women become pregnant (Htun 2013; Sato and Iwasawa 2006). Due to this, the abortion rate in Japan is high compared to other developed nations.

As we will see below, the dominant schemas available to interpret women's health issues in the Japanese development imaginary reflect this gender and health legacy. INGOs implement activities which maintain the assumption that women are the primary caretakers of children, support investment in state-led maternal child health services, and do not address reproductive health.

The Development Imaginary in Action: Women's Health Program Construction in Tokyo.

In this section, I investigate how the Japanese development imaginary impacts women's health programming, beginning with an investigation of JICA's gender and health priorities and then, analyzing INGOs in Tokyo. First, JICA does maintain a small number of gender and development programs. In doing so, it engages selectively in global gender rhetoric. However, JICA selects gender and development priorities that are appropriate within the Japanese development imaginary, fit with Japan's development experience and, often, are politically neutral. In public reports on gender and development like the "Thematic Guidelines for Gender & Development," JICA explains the shift from Women in Development to Gender in Development and the importance of promoting gender equality as defined by the OECD's Development Assistance Committee. It states:

> Gender equality does not mean that men and women become the same, but aims to realize a society where equal opportunities and life chances are provided to both men and women, so that everyone can achieve self-fulfillment regardless of gender [JICA 2009].

The report promotes the importance of 'gender mainstreaming' and ensuring all current and future development programs funded by JICA are sensitive to the distinct needs of men and women. JICA also has three gender and development Strategic Development Objectives (SDOs).

In table 3 below, JICA's objectives can be compared to the objects of DFID's Strategic Vision for Gender Equality and USAID's Gender Equality and Women's Empowerment Strategy presented in the previous chapter.

Table 3

JICA	DFID	USAID
• As for SDO 1, JICA will further engage in cooperation for the development of human and institutional capacities of national machineries and gender-sensitive policies, institutions, and programs. • As for SDO 2, JICA will engage in emerging issues such as countermeasures against trafficking in persons, in addition to providing continuous assistance in the areas of direct concern to women, such as reproductive health and medical care, basic education, skills and vocational training, and agriculture, forestry and fisheries development. • As for SDO 3, JICA's commitment to gender mainstreaming varies by sector: Gender mainstreaming in forest management, rural development, and rural water supply is relatively advanced, whereas further efforts are required in other sectors. When assistance projects are anticipated to have direct or indirect impacts on rural communities, social and gender analysis is indispensable (JICA 2009).	• Challenge and change unequal power relations between men and women, and negative attitudes and discriminatory practices that hold women and girls back • Build the inter-linked foundations which will have a transformational impact for girls and women: elimination of violence against women and girls; access to sexual and reproductive health and rights; girls' education; and women's economic and political empowerment, including an increase in women's participation and leadership in conflict prevention and peacebuilding processes, at community and national levels. • Protect and empower girls and women in conflict, protracted crises and humanitarian emergencies, to rebuild their lives and societies, by listening to their needs and by increasing the meaningful and representative participation and leadership of women. • Leave no girl or woman behind. Focus where progress is slowest because of multiple discrimination or disadvantage, including for girls and women with disabilities. • Integrate gender equality in all our work across the board and track delivery through to results - on jobs, trade, tax systems and the world economy; new technologies; modern slavery; climate change; nutrition; tackling AIDS; infrastructure; and peace agreements.	• Integrate gender equality and female empowerment into USAID's work: This policy will be implemented by integrating approaches and actions to advance gender equality and female empowerment throughout the Program Cycle • Pursue an inclusive approach to foster equality: This policy is inclusive of all women and men, girls and boys, regard less of age, sexual orientation, gender identity, disability status, religion, ethnicity, socioeconomic status, geographic area, migratory status, forced displacement, or HIV/AIDS status. • Build partnerships across a wide range of stakeholders: USAID will partner with a wide range of key actors to ensure that our efforts to increase gender equality and female empow erment are coordinated and nonduplicative, and reflect country priorities. This includes host governments; international and host country civil society; women's organizations; the donor commu nity, foundations; lesbian, gay, bisexual and transgender advocates; and the private sector, including womenled businesses. USAID's partnerships with local individuals and organizations will capitalize on and leverage their passion, experience, and achievements, while building their capacity as advocates, leaders, and voices for change. • Harness science, technology, and innovation to reduce gender gaps and empower women and girls: USAID interventions to promote gender equality and female empower ment should make bold, imaginative, and creative use of new technologies and innovations that hold great promise

		for increasing men's and women's health and wellbeing. • Address the unique challenges in crisis and conflict affected environments: USAID's work in crisis, conflict affected, and fragile states will facilitate women's participation in peace processes and decision-making, promote women's roles in conflict prevention and recovery, strengthen its efforts to pre vent and protect women from gender-based violence, ensure that relief and recovery efforts are specifically responsive to the different needs and priorities of women and men, and enable women's safe and equitable access to assistance, services, and livelihood support. • Serve as a thought-leader and a learning community: USAID will measure performance in closing key gender gaps and empowering women and girls. Monitoring and evaluation methods should include indicators that measure progress toward gender equality and women's empowerment • Hold ourselves accountable: Promoting gender equality and female empowerment is a shared Agency responsibility and depends on the contribution and collective commitment of all staff.

In contrast to USAID and DFID, JICA's goals describe women's health and education needs as well as recommend that gender analyses be conducted, but do not address power or inequality. A review of JICA's ODA or country-to-country projects illustrates it also selects gender and development program activities that largely provide aid to women without addressing gender power differentials in recipient nations. On its website, JICA specifies the below five gender priority areas, for which I provide example projects in table 4 (JICA 2012):

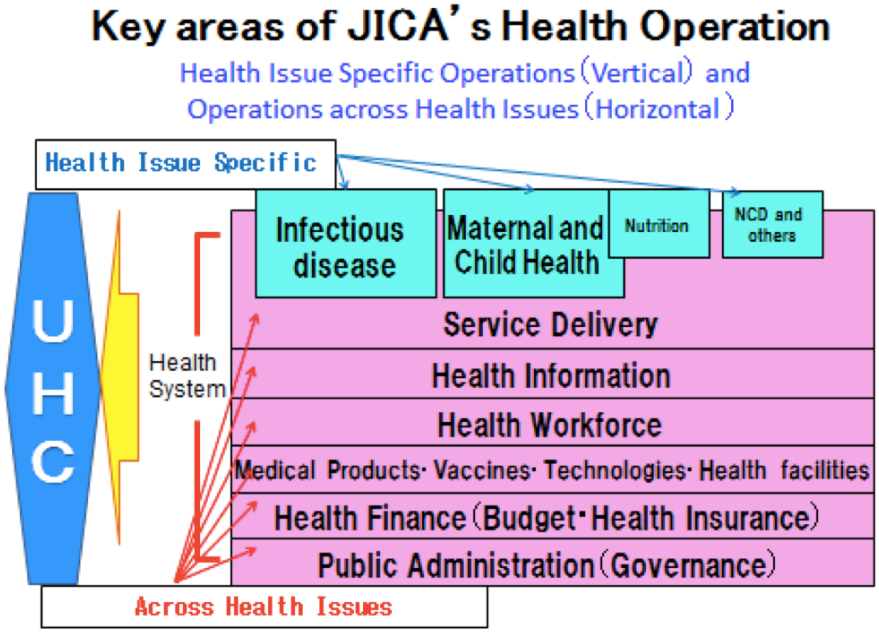
Table 4

Priority Area	Types of Activities
Women's Economic Empowerment	In Cambodia, JICA funded a project and provided technical assistance for the MOWA to implement it. Following the 'one village one product' development program implemented in Japan, women in rural villages were encouraged to raise chickens or create vegetable gardens to earn extra income for the home.
Women's Rights & Security	Training female police officers to look for signs of human trafficking in Afghanistan.
Women's Health & Education	Helping national governments develop and implement Maternal Child Health Handbooks.
Promoting Gender Responsive Government	Support to Ministry of Women's Affairs to create policies or implement services for women.
Promoting Gender Responsive Infrastructure	JICA provided loan to construct metro in India that required the metro be woman-friendly, with things like women-only cars as they have in Tokyo (JICA interviewee explanation 2019).

One Japanese bilateral interviewee in Tokyo informs me that when it comes to gender programs, she thinks its "most important to increase the abilities of the women's ministry" in developing nations. Thus, in line with its development imaginary, JICA sees the state as the appropriate site for addressing gender, supporting state agencies devoted to women's issues. On the whole, in recent years, gender has received limited investment from JICA. JICA's gender department, the Office for Gender Equality and Poverty Reduction is limited in staff with fewer than 10 employees, and no JICA country office maintains a gender expert. No bilateral agency interviewee employed any gender and development 'buzzwords' such as women's empowerment, rights, or equality.

When it comes to health programming, JICA interviewees and the JICA website proudly promote the health sector as having paramount importance within Japan's aid profile. JICA interviewees enthusiastically report that Japan values working on Sustainable Development Goal three – good health and well-being, which includes the goal of Universal Healthcare. JICA particularly emphasizes the areas of child and newborn health, infectious disease, maternal health, and nutrition. Its strategies for improving these areas include a focus on public health system and strengthening and the transfer of Japanese expertise and technology (JICA 2013). A 2013 JICA report provides the following chart documenting how it will pursue universal health care in developing nations, showing that maternal and child health is one of the major priority areas for Japanese aid. It is included below as figure 3.

Figure 3



(JICA 2016)

As for its women's health priorities, JICA's "Japan Brand ODA" report on Maternal Child Health states, "The ultimate aim of JICA's cooperation in the area of maternal and child health is to enable each country's government so that they can provide support for women at each stage of life, from adolescence through pregnancy and childbirth to child-rearing" (JICA 2016). While noting that attention to recipient context is important, another JICA report suggests that developing countries can learn from Japan's success with maternal and child health promotion through what it calls "women-only professions" (nurses and midwives), training community health volunteers, the development of Japan's MCH handbook, and increasing the number and quality of birthing centers (JICA 2005: 73).

In terms of family planning and reproductive health, JICA's activities are limited. Examples of family planning technical activities are few and far between on JICA's public website. Where they do exist, they are typically combined with, and take a backseat to, maternal child health activities. When asked about family planning, one JICA interviewee reports, "well we do not often work on that health topic."

While Japanese INGOs must follow JICA's priorities, as discussed above, JICA does not specify projects in its call for proposals, giving INGO practitioners considerable leeway in designing women's health projects to be implemented in developing countries. Project design is

usually conducted in discussions with Japanese staff in the country office, headquarters staff make field visits to collect data in recipient nations, and in consultation with JICA officials.

Following JICA, Japanese INGOs implementing women's health programs do not engage with the rhetoric around civil society advocacy or democracy building and none support local NGOs in recipient nations. Surprisingly, for women's health projects, INGO practitioners largely do not engage with the global norm of gender equality. When I tell Dr. Ito, a long-term INGO employee and consultant at Volunteers United, about my research project, she immediately warns me: "Japanese NGOs… well… most of them do not promote "gender" issues or do advocacy like that… they don't think about gender like you do." She goes on to explain why she thinks this might be the case:

> Japan is very low on the gender indexes…I don't think feminism and gender empowerment like you think of it is in Japan…although there are a small number who are raising their voices about sexual harassment and sexual violence… when it comes to everyday life… I think the younger generation in Japan resists quietly, they don't get married, continue to work…. Have more economic independence than their mothers or grandmothers… even though there are still problems with women's wages being low…more often we are quiet in Japan so we don't talk about it [gender] in NGOs the way you do…

In D.C. interviews, the topic of gender equality or the need to improve women's place in society in some capacity is a taken for granted assumption, and it is raised without my prompting in any programming discussion, but particularly for programs in women's health. Comparatively, references to 'gender equality,' 'gender and development,' 'women's empowerment,' or 'reproductive rights' are absent in Tokyo.

When I do inquire about gender, most Japanese INGO interviewees respond briefly, by noting how their activities help poor women or mothers. Most are unaware JICA maintains a gender policy. When asked about gender a few Japanese INGO employees offer responses similar to those provided when they are asked about political advocacy, explaining that Japanese INGOs do not like to "intervene in another nation's culture." With little explicit discussion of gender, program construction often assumed that the mother is the primary caretaker in the family. Interviewees rarely, if ever, discuss the role of the father. Evidence for this is particularly strong in the success stories provided in the program report of health INGO, Mother's Heart.

> There was a woman in [location of] village that did not trust the local health center at all. Instead, she entrusted her and her family's healthcare to a traditional birth attendant and a traditional healer in her village. She was comfortable asking her traditional birth attendant to assist her in delivery. She did not want to go to the health center, because she felt shy and was afraid of the

> health center staff. The health of children was not very good, because she had limited knowledge of health and nutrition issues and hygiene conditions at her home were not very good.
> Then, a VHSG [public village volunteer] invited her to join in health education activity organized by VHSG, health center staff, and [Mother's Heart]. After this education activity, she understood the message and was not afraid to see health center staff. She takes her children to get vaccinated and for treatment when they are ill at the public health center. She has also cleaned her house, drinks only boiled water, and feeds her children more nutritious food. With these new habits, her family's health condition is much improved.

All practitioners from INGOs implementing maternal child health programs describe program activities that only educate women on nutrition and health during pregnancy and for children under two, effectively assuming mothers will be the main caretakers of children's health. As we will see in Chapter Four, this has consequences for program outcomes in the Cambodian context.

Nevertheless, as we see in the program report above, we do see the prominence of the developmental state in women's health programming. All Japanese INGOs implementing health programs in my sample cooperated with the recipient government to do so. Activities promote the Japanese experience and expertise as a model for strong public health sectors in recipient states. INGOs encouraged the use of an MCH Handbook, supported public health workers in provinces and rural communities, or actively improved health infrastructure, through funding the building of health centers or providing medical equipment. A program director at Together International explains:

> Since we wanted to work with the community, the health centers are first priority. The primary health center is where community services are provided through the government, and most of the services provided at the health centers are for maternal and child health….then, we also work with the government's community volunteers…we gather them at health center and we discuss their role, what are they supposed to do, and tell them this is the government policy for their role. Then, we have the training to learn about… maternal and child health and also every month we conduct meetings, so the volunteers report how many pregnant women [are] in the village and what are the health problems of women to the public health centers.

INGOs implementing women's health programs generally support technical programs in cooperation with state actors to upgrade women's health services, ignoring reproductive health and gender relations.

Furthermore, we can also see the importance of Japanese academics in women's health programs. Japanese INGOs implementing maternal child health programs report spending enormous amounts of time and energy ensuring their local implementing partners are "modern" health experts by flying in Japanese doctors or professors to provide trainings. Furthermore, following the separation of INGOs from the market, no INGO implementing women's health

programs cooperated with the private healthcare sector or sought organizational sustainability through the market.

However, there is one exception to the general trend described above, that no Japanese INGO discussed family planning. I observe an INGO conduct a JICA funded two-day maternal health training for government officials from Africa. The INGO conducting the training, Family Planning Japan, (FPJ) is the oldest development organization I interview in Tokyo. FPJ is a unique organization among Japanese INGOs as it began international activities in 1974. It was funded by the Ministry of Foreign Affairs to conduct integrated programing for parasite control and family planning abroad, after success with those activities in post-war Japan. FPJ is the only INGO in my sample to discuss reproductive health and implement activities related to it. FPJ also maintains a number of multilateral donors, unlike many smaller Japanese INGOs, and my interviewee explains she believes in "reproductive choice" and the need to improve family planning in Japan. Yet, several other INGO interviewees in Tokyo tell me they consider FPJ a "government NGO" as it was basically a contractor for the Ministry of Foreign Affairs when it began, has worked very closely with MOFA and JICA through the years, and gains the majority of its funds from implementing JICA trainings.

At the maternal health and family planning training I observe I sit in the back of the large training room, at a table with multiple observing JICA officials. In front of us, sit eight government MCH experts from Niger, Sierra Leone, Uganda, and Namibia. Five are male and three are female. The JICA official leading their trip to Japan explains to me the participants are all midwives or doctors and each has been selected by their own government to attend training in Japan for six weeks. After workshops in Tokyo, the group will be traveling to different prefectures to observe in maternal and child health clinics.

A FPJ trainer leads the workshop in English. She begins by drawing a stick figure of a smiling pregnant woman. She asks participants "what will keep her happy?" The participants offer responses like access to antenatal care, a partner who provides support, financially and emotionally, extended family support, supportive health workers, and knowledge about her food and baby's health. After affirming their responses, the trainer spends the day providing officials with information about post- and pre-natal care, delivery standards, maternal nutrition, and newborn nutrition in a "continuum of care" model for mothers. She juxtaposes the continuum of care model with "traditional medicine models" that are dangerous for mothers. The trainees swap

stories of the "crazy aunties and grandmothers" committed to traditional medicine. For instance, one official tells the story of an expectant grandmother who brought traditional herbs to the birthing center and tried to give them to their daughter when the midwife was not looking.

The training covers the topics pregnant women need to know such as proper nutrition, breastfeeding, healthcare, and even the need for mothers to learn about family planning in the third trimester as their next "pregnancy should be a choice." Trainees are then asked to plan and role play their "communication strategies" to train local government officials in their countries on how to provide this medical information to women. After this medical information is presented, the trainer begins a discussion about how trainees can improve their government's maternal child health policies and the implementation of those policies. First, she asks, "what did Japan do?" She presents the "Japanese experience as a collaboration from the top and bottom" examining national policies to community health workers in prefectures. She details Japan's maternal child health history for officials, including the public nurses, the MCH handbook, and government healthcare infrastructure discussed above. She shows old photos of postwar Japan comparing them with the "Japan they see today."

Trainees discuss how Japan's policies can or cannot be used in their countries. Participants express concern their governments "will not move without payment" or might lack the resources to implement Japan-style maternal child health policies. FPJ's trainer largely glosses over these concerns, urging trainees to "be creative and persistent." Trainees "plan an effective advocacy strategy," which FPJ defines as securing support from the government for policy-making and implementation in the area of maternal child health. Trainees discuss how to build relationships with decision-makers in government, how to frame their message around the "universal good" of improving the health and nutrition of young children, and convince "their friends" in the national government.

In this training, there is a discussion of family planning for pregnant women and new mothers, and FPJ is the only organization to engage with this topic, diverging from the general pattern above. Yet, at the same time, we can still see the Japanese imaginary in the strong promotion of the Japanese state's experience, the Japanese interpretation of the global norm 'advocacy' as befriending government officials, and an emphasis on recipient state provision of maternal and child health services.

Finally, the dominant schemas in Japan's development imaginary, particularly the emphasis on developing the state, are sometimes challenged by practitioners in Tokyo. INGO practitioners explain to me that, depending on the recipient nation, sometimes accessing state decision-makers and supporting state officials in the implementation of maternal and child health services can be difficult. Interviewees lament that supporting state implementation is a long-term activity, and it can often take ten or more years to build the capacity of state officials. This is much longer than the 3-to-5-year life of a bilateral grant. Staff at INGO headquarters often revise proposals to make program activities sound "somewhat different," such as highlighting infant nutrition in the first proposal and then, maternal health in the next in order to continue their project with another bilateral grant. Others say they piece together funding from companies in order to continue their work. However, some staff simply call the expectation for INGOs to help create strong local state agencies "unrealistic" in the time allotted.

The Imagined "Other"

In conclusion, now that we have examined the development imaginary in Tokyo, it is necessary to return again to the question of what distant Other practitioners imagine their program will aid. In contrast to the imagined beneficiary of the U.S. imaginary -- a consumer in need of empowerment -- the Japanese imaginary envisions a generalized mother whose main social role is caring for her family. Yet, she is in unable to do so successfully due to her lack of public health services and information. She is mired in traditional health practices and deserving of government provision. Partnering with recipient governments and Japanese experts, Japanese INGOs promote programs that upgrade recipient state policies and services and educate both government officials and mothers.

In conclusion, to provide aid to imagined beneficiaries, INGO headquarters staff and donors in Washington D.C. and Tokyo construct and fund different programs, which entail distinctive partnerships in recipient nations. These programs are created by practitioners embedded within the national development imaginaries of the U.S and Japan. However, donor and headquarter organizations are not the only players in global aid chains. There is still ample space for other organizations in the chain to modify, resist, and co-opt donor and headquarter programming. As we will see, modification takes place through the agency of practitioners and stakeholders in recipient nations but also because of the multiple, and sometimes contradictory

goals, within the national development imaginaries themselves. The next part of this manuscript analyzes the trajectories of the two national development imaginaries as well as resulting programs and practices discussed here as they travel through the aid chain to the Cambodian context.

Chapter Four
"Kingdom of NGOs": The Cambodian Context

Before investigating how the programs and practices constructed within the national development imaginaries of the U.S. and Japan travel through global aid chains to impact Cambodia, it is necessary to provide relevant background information on the Cambodian context. Cambodia is a nation with one of the highest concentrations of NGOs in the world (Frewer 2013). Biking around the bustling, rapidly developing cityscape of Phnom Penh, one cannot miss the endless array of infrastructure projects, offices, and cars all branded with logos of different international donors and NGOs. So, many in fact, that one interviewee from GIZ, the German bilateral agency, refers to the country as a "kingdom of NGOs," a play on Cambodia's official slogan, "kingdom of wonder."

Since the early 1990s, international development organizations have played an influential role in policy-making and service provision in Cambodia. In 2010, development assistance made up 61 percent of the nation's budget (ODC 2016). Although that number has decreased in recent years, hitting approximately 30 percent in 2016, development organizations are still deeply embedded in the Cambodian government and everyday life (ODC 2016). Foreign technical advisors from the U.S., Europe, Australia, Japan, and South Korea can be found in almost every government ministry. INGOs and local NGOs, like the ones in this study, span the country implementing social welfare services and supporting citizen advocacy (Ear 2012). Why, exactly, is this the case?

In January 1979, Vietnamese troops captured Phnom Penh from the Khmer Rouge. However, civil war continued to plague Cambodia until 1991. In that year, the pro-Vietnamese Cambodian government and Khmer Rouge rebels signed the Paris Peace Accords agreeing to disarmament and elections. Subsequently, the United Nations sent in a peacekeeping operation in 1992 known as the United Nations Transitional Authority in Cambodia (UNTAC) to assist with the formation of a new government, fair elections, and economic liberalization (Hughes & Un 2011). At this time, Cambodia established itself as a constitutional monarchy where the prime minister acts as head of the government and the king is head of state. There is also a legislative

branch that consists of the senate and national assembly, and a judiciary branch with seventeen Supreme Court members[12] (Un 2011).

In the UNTAC era, numerous international funding opportunities attracted INGOs from around the world to Cambodia, and supported the founding of multiple local NGOs (Hughes 2007; Un 2011). These organizations played an essential role in developing ministry policies, ensuring democratic elections, and providing needed social services. Thus, in contrast to many other Southeast Asian nations, INGOs held, at least in the UNTAC era and the following decade, substantial authority in the Cambodian context.

In the first election set up in the UNTAC era, two parties gained prominence: a royalist party, FUNCINPEC, led by Prince Norodom Ranariddh, and the Cambodian People's Party (CPP), led by a former Vietnamese[13] appointed prime minister, Hun Sen. FUNCINPEC won the first election. In response, the CPP threatened to succeed from the government with the rural provinces that supported it. Consequently, the two parties entered a coalition government with two prime ministers. In 1997 violence between the two parties escalated with the CPP forcing Prince Ranariddh into exile. In 1998, the CPP won the general elections, with the FUNCINPEC as the junior partner. By 2006, the CPP consolidated power through extensive patronage networks, vote buying, and intimidation to become the dominant party in Cambodia, marginalizing opposition parties (Chandler 2007; Un 2011).

Part of the CPP's efforts to consolidate power includes restrictions on civil society organizations, particularly on NGOs promoting voter accountability, democratic transparency, human rights, and collective action (Un 2011). In 2010, the CPP drafted and the legislative branch passed the Law on Associations and NGOs (LANGO). This law requires all international and local NGOs to register with the government in order to work in Cambodia. The government maintains complete control over this registration process, and all organizations are required to be politically neutral. The LANGO significantly shrank civil society space within Cambodia. The law has gone through distinct periods of enforcement and restriction as well as easing since it

[12] However, the judicial branch was not set up until 1997 and is known to serve the interests of the dominant party.
[13] While Vietnamese troops did end the violent Khmer Rouge regime, many Khmer people considered the Vietnamese government control over Cambodia from 1979 to 1991 an invasion of a foreign government. Relations between Cambodia and Vietnam remain tense to this day.

passed (ICNL 2017; Un 2011).[14] Nevertheless, there are still almost 2,000 active NGOs in Cambodia today (CCC 2020).

Scholars debate the impact of foreign aid and NGOs in Cambodia. Some document how INGOs and foreign donors are able to provide support and space for advocacy groups, fund needed services, and challenge inequalities (Hiwasa 2014; Lilja 2016; Öjendal 2014). Others argue that in the Cambodian context, INGOs and local NGOs have not been successful enough in stimulating grassroots engagement and participation. Copious foreign aid has made Cambodia an "aid dependent" nation and civil society is "top down" with large INGOs and foreign donors holding a lot of power (Ear 2012; Un 2011).

Specifically, some scholars argue aid dependence contributes to the 'weakness' of the Cambodian state (Ear 2012). Throughout the early 2000s, Cambodia was regarded as a state with low capacity (Hughes and Conway 2003). In 2008, Brookings ranked Cambodia thirty-four out of fifty on its Index of Weakest States.[15] Despite continued progress, in 2018, Cambodia still ranked below the world median for its "government effectiveness value." This is a measure of public perception of government service quality, civil service quality and the government's degree of independence from political pressures, the quality of policy-making and implementation, and the credibility of a government's commitment to its policies (World Bank 2018).

The Cambodian state's limited capacity stems from the government's high dependence on patron-client ties. Patronage has a long history in Cambodia; pre-colonial rule was based on a patronage system in which the king was at the apex (Chandler 2007). The dominant political party, the Cambodian People's Party (CPP), continues the tradition today, cultivating patronage networks that link the Party to business tycoons and rural voters alike (Baaz and Lilja 2014; Un 2005). Nevertheless, in recent years, international and domestic changes have impacted the nature of Cambodia's political system and aid dependence.

[14] There is a developing literature on NGOs in authoritarian political contexts. On one hand, this literature documents that repressive polities can de-radicalize NGO advocacy and limit local organizations' access to state resources, fostering dependence on international donors (Ron, Pandya, & Crow 2016). In contrast, repressive governments can also foster resistance, NGO activism, and creative agency on the part of practitioners (Ray & Korteweg 1999; Spires, 2011).

[15] States are ranked from weakest to less weak in terms of economic, political, security, and social indicators. Cambodia scored best in economic development (4th highest quintile), moderately in security and social indicators (2nd lowest quintile), and poorly in terms of political indicators (bottom quintile).

Geopolitical Shifts in Cambodia

Currently, the nature of Cambodia's development sector is changing. As discussed in the introduction, political and economic transitions are impacting development funding in Cambodia. First, as discussed in Chapter One, in 2016, Cambodia gained lower middle-income country status (World Bank 2016). This status meant significant decreases in funding from traditional donors from the U.S., Europe, and Australia. Additionally, there has been a political and economic shift towards Asia. The prime minister is also emphasizing the fourth plank in Cambodia's National Development Plan, which emphasizes regional integration and intra-Asia relations. Foreign Direct Investment (FDI) in Cambodia is increasingly dominated by Asian investors. In 2019, the largest investors were all Asian nations -- 22 percent of FDI came from China, 6 percent from South Korea, 5 percent from the UK, 4 percent from Malaysia, 3 percent from Japan, 3 percent from Hong Kong, and 2 percent from Vietnam (CDC 2019).

Alongside economic shifts changing the influence of development donors, the CPP has continued to consolidate power. In 2013, a new party gained prominence, challenging the CPP, the Cambodia National Rescue Party (CNRP). This 'party that will rescue the nation' was founded on the premise of strengthening democracy and human rights in Cambodia. In the local commune elections[16] that took place in the summer of 2017, a large number of commune leaders elected were members of the CNRP (Channyda 2017). Due to the perceived threat to its power at the local level, in September 2017 the CPP jailed the CNRP party leader, Kem Sokha accusing him of treason for colluding with America to overthrow the Cambodian government. CPP leaders then pressured the Cambodian Supreme Court to dissolve the CNRP, its only real opposition, in the upcoming national elections scheduled to take place in July of 2018. In November 2017, the Court effectively dissolved the CNRP (Peou 2020).

In response to these developments, some Western nations further decreased aid to Cambodia, particular to democracy and governance programming. In reaction, the Cambodian government has increasingly turned towards East Asia. In response to the political upheaval, Prime Minister Hun Sen postured that the U.S. and the EU can cut aid since the government has secured promises from China to replace that money, largely through loans (Thul 2017). Relatedly, Korean and Japanese aid amounts did not change after the above events. Moreover,

[16] Cambodia is broken up into twenty-four provinces, which are then divided into districts. Districts are further separated into communes, which are made up of villages.

most Korean and Japanese INGOs are unaffected by these political tensions, continuing to work closely with the Cambodian government. Thus, this political context provides an interesting case in which the recipient state intervenes in Japanese and American aid chains differently due to geopolitical relations. The historical relationships between the two countries will be described briefly below.

U.S. Development Aid to Cambodia

Cambodia was caught in the crossfire of the Vietnam War. In 1970, the U.S. discovered that the Cambodian prime minister, Prince Sihanouk was cooperating with the Viet Cong. Thus, the U.S. government backed a military coup overthrowing the Prince's government and replaced him with Lon Nol as the prime minister of Cambodia. The U.S. provided Lon Nol's government with ample military support from 1970 to 1975 to fight the rising communist regime, the Khmer Rouge and their North Vietnamese allies. Then, when the Vietnam War ended, the U.S. abruptly ended funding to Cambodia. In the absence of U.S. support, Lon Nol's government was unable to maintain power, and the Khmer Rouge took control of the nation. After this, Cambodia experienced the violent Khmer Rouge regime and then a civil war that lasted until 1991 (Chandler, 2007).

The U.S. re-established economic and aid relations with Cambodia in 1992. USAID returned to Cambodia at this time, first to serve immediate post-conflict needs and then to provide long-term aid. Currently, the U.S. is the largest donor to INGOs in Cambodia, and USAID funds programs that address democracy, human rights, good governance, rural development, environment, health, education & child protection, and female empowerment in Cambodia. In 2017, USAID gave 67 million USD to Cambodia with the majority of this aid being disbursed via contracts and grants to INGOs and/or international foundations (USAID, 2018).

Yet, since the commune elections in the summer of 2017, U.S. development organizations have been embroiled in the rising political tensions in Cambodia. Part of Prime Minister Hun Sen's justification for ousting the CNRP was the accusation that Kem Sokha was colluding with America to ruin Cambodia's stability, just as the U.S. did with the Lon Nol government. In response, in 2017, USAID released a press release stating, "The Cambodian government's disenfranchisement of millions of its citizens undermines fundamental principles

of democracy and rule of law, and endangers Cambodia's economic prosperity and international standing." INGOs originating in the U.S. and implementing democracy promotion programs in Cambodia have been shut down, including the National Democratic Institute, which received 2.1 million USD in funding from USAID in 2016. Many other INGOs originating in the U.S. face political repression and a difficult political context in Cambodia. While things have improved somewhat since 2017, at the time of this research tensions were still high between USAID and the Cambodian government.

Japanese Development Aid to Cambodia

The modern history of Japanese relations with Cambodia begins when the Japanese military overthrew the French colonial government in 1945 during World War II. The Japanese military then pushed the Cambodian King to declare an independent state. Later that same year, Allied forces pushed the Japanese out of Cambodia (Chandler, 2007). In 1954, Japan established bilateral relations with Cambodia, but these relations were largely intermittent due to political turbulence in Cambodia (Kung, 2015). Japan reestablished diplomatic relations with the country during the UNTAC era, sent peace keeping personnel in 1992, and played a key role supporting the Cambodian government after the Khmer Rouge (Embassy of Japan 2020; Kato, 2016). A Japanese citizen, Akashi Yasushi, headed the UNTAC (Er 2013). As discussed in Chapter Three, a number of the Japanese NGOs active in Cambodia today began as aid organizations helping Khmer Rouge refugees at Thai border camps (Hirata 2004).

Since this time, Japan has been one of Cambodia's top OECD donors, investing loans and grants in the country's infrastructure and technical expertise. Between 1992 and 2007, Japan provided a total of 1.2 billion USD in official development assistance to the nation (Jones 2008). In 2015, Japan's total bilateral aid, including grants, loans, and technical cooperation totaled at 286.57 million USD compared to U.S. foreign assistance for social programs and de-mining operations which totaled 74.5 million USD (Open Development Cambodia 2015). In part funding discrepancies come from a wider range of funding provided by Japan. JICA provides aid directly to the Cambodian government, via a request-based program in which state officials make requests for assistance, which JICA selectively grants. It also provides loans to the Cambodian government. USAID does not support the Cambodian government directly or provide loans.

Due to this history, Japanese aid, investment, and products are generally well regarded by Cambodian citizens. Political relations between the two nations are generally positive. Several high-ranking government officials, including the Prime Minister, have reportedly stated that there is a "special relationship" between Cambodia and Japan (Jones 2008). As we will see in the next chapters, Japan's relationship with Cambodia provides a different political situation in which Japanese INGOs conduct their work. However, before discussing the work of Global Family Aid (GFA) and Health Services Asia (HSA) in Cambodia, below I provide necessary information on the gender and health context in which programs are implemented.

Gender & Development in Cambodia

In this section, I will first discuss gender norms and the position of women in Cambodia society generally and then, move to a discussion of gender, development, and NGOs in the country. Chapter Five and Seven include a number of references to 'traditional' gender norms in Cambodia. When participants refer to 'traditional' gender norms in Cambodia, they are typically referencing well-known Khmer cultural norms that assume men will enact roles like breadwinner, political leader, and head of the household. It is also culturally acceptable for men to be sexually promiscuous. In contrast, women are assigned the majority of household and childcare duties, a limited role in the political sphere, and cultural norms strongly promote female protection and chastity. For instance, take the Cbpab Srey, a Khmer poem or female code of conduct that has been passed down since the 14th Century and is still taught in Cambodian public schools today. It promotes women who are submissive, quiet, and stay home to tend to household duties. It famously compares girls to cloth, whose virtue is easily soiled by sexual promiscuity while boys are likened to gold (Anderson & Grace 2018).

Traditional gender norms continue to impact Cambodians today. Women who act in ways that challenge traditional norms can face violence. Twenty-one percent of Khmer women ages 15-64 who had ever been in a relationship report experiencing physical violence at least once. Fifty-one percent of Cambodian women agree that wife beating can be justified, often in cases in which the wife was sexually promiscuous or did not perform household duties (CDHS 2014). Furthermore, there are very few women in management and leadership positions in the economic and political sectors in Cambodia and 56 percent of the Cambodian population believes men are better political leaders than women (ADB 2014; SIGI 2019).

At the same time, many participants believe gender norms are changing and there are multiple ways to be a 'good woman' in Cambodia today. Cambodia has a high rate of female labor force participation, with 82 percent of women working in the formal labor market versus 88 percent of men (CDHS 2014). Many practitioners argue that while men still often maintain higher paying jobs, women are expected to be active in the economic sector, and working to provide for the family is another way to be a good woman. Cambodian women are also traditionally in charge of household budgets and small-scale financial decision-making within the family (Anderson & Grace, 2018; USAID, 2016).

Finally, it is essential to note in a discussion of gender norms that the categories male and female are not homogenous categories; intersecting identities, such as geographic location, religion, age, and socioeconomic status, shape people's needs, experiences, and social expectations in Cambodia. The gendered experiences of young, unmarried urban women working in factories outside of Phnom Penh are very different from rural women who are part of the Cham Muslim minority in Cambodia.

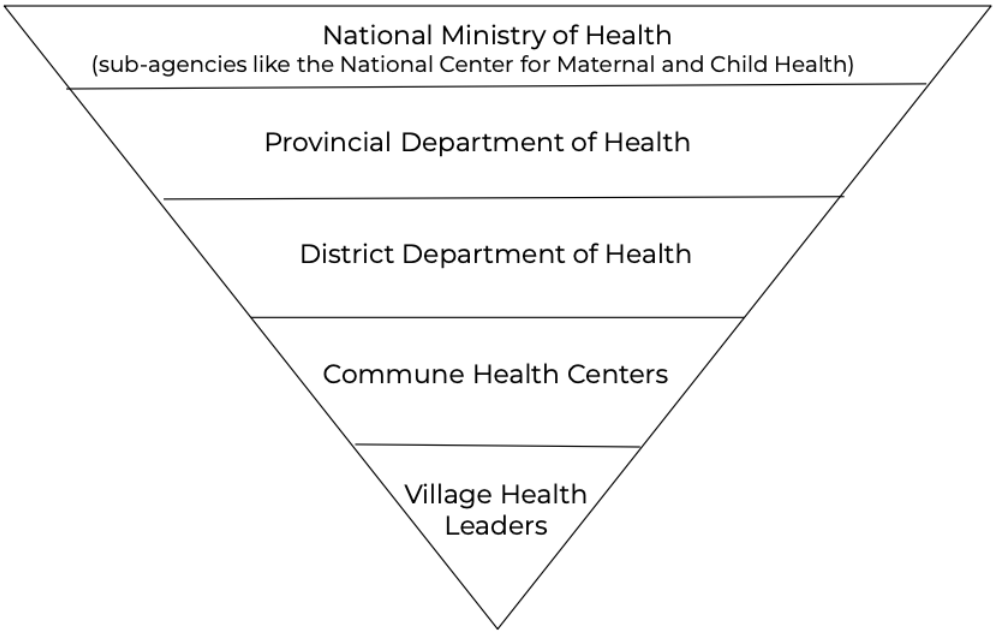
NGOs addressing women and development, and later gender and development, began popping up in Cambodia as early as 1993. It is important to note that the history of women's organizing and female leadership in Cambodia does not start with international intervention. Cambodia had several domestic women's groups advocating for gender equality and independence from France in the 1960s. Additionally, the female family members of political leaders, like the current prime minister's wife, Bun Rany, have long held influential positions in Cambodian society (Frieson 2001). However, due to the expansive number of foreign donors, a large portion of the work done to combat gender inequality in the country today maintain takes place in NGOs. In 2018, over 100 international and local NGOs listed on the Cambodian Cooperation Committee's NGO database listed gender or women's development as the main focus of their work. Hundreds more, of the almost 2,000 NGOs registered in the country, conduct projects addressing gender inequality or women's empowerment, while identifying their organization with a different sector. For example, health organizations implement that reproductive health programs or the small human rights organizations supporting female activists fighting land grabs are also addressing gender inequalities in their programming (Rose-Jensen, 2017). Thus, it is within this gender and development context that the INGOs in this study implement women's health programs.

The Cambodian Health System

With careful planning and large amounts of donor support, the Cambodian health system has made great strides, enacting substantial reforms since the UNTAC era of the early 1990s. The Cambodian populations' life expectancy increased from 29.6 years in 1980 to 71.4 years in 2012 and access to healthcare has greatly expanded (WHO 2016). In Cambodia, the healthcare system is mixed, including public and private options for care. The public system is structed as follows: the Ministry of Health (MOH) is the leading force in planning, developing, and overseeing the national health system. Then, the country is broken up into provinces so the MOH oversees a provincial health department and a provincial hospital in each of the nation's 24 provinces. Next, each provincial health department oversees the operating districts and district referral hospitals. There are 88 districts in the country total (several per province) and the number of districts a provincial health department oversees depends on the population size and geographic area (WHO 2016; UNFPA 2015).

At the next level, the districts are broken into communes. District health departments oversee health centers and health posts in their communes. There are an estimated 1,105 health centers in the country (not all communes have a health center, the number of health centers in a district depends on its geographic size and population). Most health centers are equipped to provide primary care, maternal and child health services, and prevention of communicable diseases. Health posts are more informal and limited health facilities, often placed in remote areas. Finally, at the village level, ideally, health centers oversee and provide a small allowance to village health support group volunteers who act as primary contacts and health educators at the village level. Village health volunteers are technically considered government volunteers and are selected by the village chief, sometimes with the input of health center workers. A simplified chart of the Cambodian public health system is provided in figure 4 below for reference.

Figure 4



While access to public healthcare has greatly improved in Cambodia since the 1990s, there are still issues. In 2010, only 43 percent of health centers offered the full minimum care required by MOH policy due to lack of human resources, technology, or drugs. Currently, people in remote areas still face difficulties accessing health services and Cambodia is still working to improve the quality of care provided by their public healthcare system (WHO 2016; UNFPA 2015). In terms of healthcare spending, in 2010, the Cambodian government funding equaled 22 percent of healthcare expenditure, spending approximately 1.4 percent of the GDP on health. It secured the funds largely from general taxation revenues and external development partners, who support approximately 50 percent of government healthcare spending. Finally, a large percentage of healthcare expenditure is made up of client out of pocket spending, which totaled approximately 73 percent (Hwang, Seap, and Kim 2016; WHO 2016).

In part, out of pocket spending is due to the fact that the Cambodian health system is also comprised of private health clinics and drugstores. In a 2008 survey, approximately 2,000 private health clinics existed in Cambodia. All private health clinics and drugstores are legally required to register with the MOH. However, in 2010, only about half were registered and even private health clinics that are registered remain under-regulated (Hwang, Seap, and Kim 2016; WHO 2016). Roughly two-thirds of public health employees also work in the private healthcare sector to increase their earnings (WHO 2016).

Cambodian clients can choose to go to private clinics, public health centers, or hospitals as they see fit. It is also reported that between 40 and 50 percent of Cambodians continue to seek care from traditional healers, often alongside getting biomedical healthcare (Bazzano et. al. 2020). Health insurance is not widely offered or used. Donor-government initiatives have emphasized affordable care for the very poor, including a health equity fund and voucher programs. While patient use of public health centers for maternal health and communicable diseases is increasing, the Khmer population prefers private clinics for curative care (WHO 2016). In the 2015 Cambodian Demographic Health Survey, when sick or injured 67 percent of Cambodians reported going to the private sector to first seek care while only about 22 percent said they sought care at a public health facility.

Finally, the Cambodian health profession is a male dominated one. Men are more likely to become medical doctors than women. Women make up a higher percentage of public sector nurses and midwives, often employed in rural health centers. In contrast, doctors are more likely to work at the district, provincial, and national level (Hwang, Seap, and Kim 2016). There remains a strong leadership bias towards men in the medical field (Vong, Ros, Morgan, and Theobald 2019). Women make up only 15 percent of those employed in leadership and management roles in the public health system and this is a particular problem at the operating district level where women only make up approximately 5 percent of those roles (Johnson 2018). Having detailed the Cambodian health system more generally, below I describe the women's health practices into which the INGOs in this study intervene.

Maternal, Infant, and Reproductive Health in Cambodia

The maternal health experience of most Cambodian women has undergone substantial change in the past twenty years. For most of modern Cambodian history, the majority of women gave birth at home with the help of a "chmop boran" or traditional birth assistant. Birthing clinics were introduced in the colonial era but were mainly used by Vietnamese and French inhabitants as most Khmer women continued to prefer to give birth at home. After independence, the head of state, Prince Norodom Sihanouk instituted training programs for at home birth assistants. However, little was done to promote maternal health during the Khmer Rouge period and subsequent Vietnamese occupation (Ros, Le, Fustukian, and McPake 2019). In the late 1990s, maternal health became a priority area in the country, due to its high maternal mortality ratio compared to other nations in the region.

Since the UNTAC era, substantial gains were made through government, donor, and NGO commitment to increasing access to healthcare, midwife training, and health education, substantially changing the experience of pregnancy and birth in Cambodia (Dingle, Powell-Jackson, and Goodman 2013). In the early 2000s, the government partnered with UNFPA to adopt the "Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality" as MOH's official policy (MOH 2016). It greatly expanded public health clinic maternal health services, including midwives on staff and health education promotion at the community level. The country made swift improvements going from a maternal mortality ratio of 437 deaths per 100,000 births in 2000 to 170 deaths per 100,000 births in 2014 (CHDS 2015; WHO 2016). Now, more than 89 percent of births take place with the help of a skill medical provider and 83 percent take place in a health facility. Also, more than 95 percent of women receive antenatal care from a medical provider, however, biomedical prenatal care is often combined with the seeking of traditional services (Bazzano et. al. 2020; CDHS 2015). Infant deaths also continue to decrease going from 45 deaths per 1,000 births in 2010 to 28 in 2014. Seventy-seven percent of newborns also received postnatal care (CDHS 2015).

In part, these improved maternal and child health outcomes were due to growth in the Cambodian economy throughout the 2000s, improving the capacity of many Cambodian citizens to pay for medical care. It was also due to the increasing effectiveness of the National Center for Maternal and Child Health (NCMCH). Despite the weakness of the Cambodian state more generally discussed above, within states with limited capacity, specific state agencies can still be effective. Effective agencies carve out a niche where the influence of patronage networks is lessened and a distinctive organizational culture can be cultivated (McDonnell 2020). The NCMCH has been able to develop its capacity for two reasons. The first is elite commitment to the sector. In the 1990s, Cambodia was known in the international community for having one of the highest maternal mortality rates in Asia. The Cambodian People's Party (CPP) provided increasing support for maternal and infant health, demanding NCMCH effectively implement changes. Currently the prime minister's own wife, Bun Ranny, serves as the honorary chair of the NCMCH. Second, NCMCH developed its capacity through the support of international donors. Foreign donors provide funding and technical support to the sector and expatriate staff for the NCMCH.

Since the early 2000s, the planning and coordination capacity of the NCMCH has progressed rapidly; the leadership and capacity of top and middle-level public officials working in the sector has improved; increasing numbers of midwives have been trained and deployed to rural health clinics; and, a substantial number of public health clinics have been constructed in remote areas (Noriko et. al. 2013). Tim Kelsall and Seiha Heng (2016) describe the process of government leaders and donors coming together to support effectiveness in the health sector through "successful multi-stakeholder initiatives" as creating "'islands of effectiveness' in a sea of rent-seeking and patronage" (238).

Nevertheless, despite significant gains, more work is needed to improve maternal and reproductive health in Cambodia (WHO 2016; UNFPA 2015). One in eleven women still die in child birth (CDHS 2015). Maternal health is also deeply impacted by geography and socioeconomic status. The fertility rate of women in the lowest socioeconomic quintile is double that of women in the highest quintile (WHO 2016). Antenatal care and giving birth in a facility remain more likely for wealthier women and urban women. Additionally, infant and childhood mortality are lower in urban areas (Dingle, Powell-Jackson, and Goodman 2013; WHO 2016). In rural areas, travel time and cost of travel remain some of the biggest factors influencing the uptake of maternal and infant health services (Hwang and Park 2019).

When it comes to family planning, although progress is slower, Cambodian government and development organizations have also worked to expand reproductive health services in the country (Dingle, Powell-Jackson, and Goodman 2013). Strong focus has been on increasing access to medical birth control and health education, including mobile phone campaigns and outreach (Smith et al. 2016). Thirty-nine percent of married women report using a "modern" method of contraception, compared to 19 percent in 2000. Of modern method users, the public health sector provides 47 percent of women with modern contraception (CDHS 2015). Finally, the Cambodian government legalized abortion in 1997 and the estimated abortion rate is approximately 50 per 1,000 women (Smith et al. 2016).

However, 12 percent of married women still report an unmet family planning need (CDHS 2015). Interestingly, the use of 'traditional' family planning methods, such as withdrawal, has increased among wealthier, educated, and urban women. Only 33 percent of urban women report using modern birth control methods, compared to 40 percent of rural women (UNFPA 2015). Furthermore, access to and education about modern family planning

continues to be limited for unmarried women and minority groups, such as sex workers or women with disabilities (Delvaux et al. 2003; Gartrell, Baesel, and Becker 2017; UNFPA 2015). Finally, abortion remains an incredibly sensitive topic and the government has made very slow progress on improving access to safe abortion (Dingle, Powell-Jackson, and Goodman 2013).

Thus, the INGOs in this study intervene in a health sector where the Cambodian government, at the national level, has a higher level of effectiveness than other sectors and a long history of cooperating with international donors. Nonetheless, there is still a substantial need to improve women's health services and education in the Cambodian context. Having examined the relationship between each INGO's donor and Cambodia as well as the gender and health contexts, the next chapter will investigate each INGO's women's health programming articulates in the Cambodian context.

Chapter Five
Modern Asian Mothers or Empowered Consumers?: Gender and Program Articulation in the Cambodian Context

In the previous chapters, I investigated development imaginaries in the donor agencies and INGO headquarters in Tokyo and Washington D.C. In this chapter, I will analyze what happens when those imaginaries, and the programs created within them, travel through the aid chain to be implemented in Cambodia. Specifically, I will examine variation in the outcomes of each INGO's women's health program activities and the gendered assumptions inherent in each aid chain. To remind the reader, the U.S. development imaginary envisions development as a market-driven process involving incorporation into the labor force. In contrast, in Tokyo, the developmental state figures prominently alongside a breadwinner livelihood strategy.

In this chapter, I explore how these imaginaries are reflected in what happens at the next links in the aid chain, examining three processes. First, program outcomes are impacted by direct INGO interventions into gender and health services in Cambodia. For instance, staff at U.S. INGO, Global Family Aid (GFA) define their mission as "empowering women and mothers to be informed healthcare consumers"; they implement programs that combine maternal and reproductive health. In contrast, Japanese staff at Health Services Asia (HSA) describe their maternal health program as helping women access effective public health services to become "modern Asian mothers." Donors and headquarter staff from the U.S. and Japan purposefully shape these conceptions of how to best advance women's health.

Second, program outcomes are also influenced by how other aspects of development imaginaries are communicated along, and shaped by, the dynamics of aid chains. For instance, in Japan, practitioners value programs that support developing states and as we will see in this chapter, this means HSA eschews partnering with local NGOs in favor of supporting the Cambodian government. In contrast, in the U.S. development imaginary, there is a strong emphasis on measurability as well as the need to support grassroots advocacy. Consistent with this, in the U.S.-based aid chain, GFA funds and monitors local NGOs, which implement its

maternal and reproductive health education activities. As we will see below, the partner organizations INGOs select shape the opportunities and constraints on local actors.

Third, development imaginaries and their resulting program goals do not automatically resonate with Cambodian stakeholders. Instead, they are mediated and adapted by the 'brokers' in our story: practitioners in GFA and HSA's Cambodia offices and implementing organizations (Swidler and Watkins 2017). Programs are translated and adapted by agentic practitioners who negotiate the Cambodian context and the logics of each aid chain. Below, examining all three factors above, I will describe how HSA and GFA's gendered programs *articulate* in the Cambodian context, with distinctive, and sometimes unintended, outcomes. I begin, however, by situating this analysis in relevant literature and explicating the concept of articulation.

Gender, NGOs, & Articulation

As noted in the Introduction, numerous studies of NGOs illustrate the practices of local practitioner translation and contestation (Cornwall, Harrison, and Whitehead 2007). In their broker role discussed in Chapter One, local practitioners creatively negotiate donor demands, global norms, beneficiary needs, and local contexts. Scholars use numerous concepts to describe translation. Below, I briefly outline two major perspectives on this translation process before arguing for the need to understand it through the lens of articulation.

As discussed in Chapter One, drawing on neoinstutional theory, world polity studies describe processes of INGO translation using the concept, decoupling. World polity theory analyzes a global organizational field, which includes actors such as states, professional organizations, corporations, multilateral organizations, and INGOs. Actors in this field interact to create agreed upon dominant global policy scripts, which are taken up by organizations around the world (Kentikelenis and Seabrooke 2017). INGOs advocate for, enact, and diffuse global scripts, gaining legitimacy in the global field (Boli and Thomas 1999; Boyle, Kim, and Longhofer 2015).

Yet, despite isomorphism in the rhetoric of global scripts, scripts are often modified or taken up in locally specific forms as they travel to different country contexts (Chorev 2012). It is this gap between policy and actual practice that world polity scholars refer to as decoupling (Meyer 2010). There are numerous reasons why a policy might be decoupled from practice in INGOs. INGO practitioners, working in specific contexts, often strategically re-interpret,

modify, or do not simply do not enact global scripts. INGO staff might purposely decouple policy and practice due to beliefs about beneficiary needs. In contrast, INGO leadership might enact a formal goal for legitimacy but lack the resources to implement it. In the 'modern world,' organizations enact increasingly opaque and, sometimes contradictory, goals that they cannot implement in practice (Meyer and Bromley 2013). For instance, INGOs and multilateral organizations engaged in humanitarian aid almost unilaterally formally commit to ensuring there is coordination between international development organizations and local governments, a goal legitimated in the global field. Yet, coordination is almost always decoupled from the actual practice of humanitarian aid, largely acting a ceremonial façade (Hensell 2015).

World polity studies provide us with important insights into the decoupling process. However, as discussed in Chapter One, world polity overemphasizes decoupling from *global scripts* ignoring the national variation in INGO programs and practices we saw in Chapter Two and Three. Second, these studies highlight isomorphism in formal scripts and decoupling practices are of secondary interest. In consequence, the translation and resistance of INGO practitioners to formal scripts is not the central concern of world polity studies.

In contrast, a second set of studies emphasizes the agency and resistance of practitioners in recipient nations and the translation process through varied concepts such as adaptation, interpretation, or re-framing (Davis 2007; Noonan 2002; Rinaldo 2013; Thayer 2010). They document numerous ways translations take place in international and local NGOs. First, international donors and transnational networks can enable practitioners in developing countries by providing practitioners and communities with a space to re-frame global issues to match the needs of their nation and mobilize around those issues (Davis 2007; Noonan 2002). For example, in Brazil, women working in a rural NGO encountered the *Our Bodies Ourselves* movement that started in Boston. Rejecting the prominence of individual sexual pleasure in the text, their interpretation of the movement instead emphasized coalition building and the demand for reproductive rights and women's health services (Thayer 2010).

Yet, as discussed in Chapter One, donor organizations can also limit possible programs by funding activities that align with their vision of development. Under such constraints, NGO practitioners are creative and resourceful actors, contesting, negotiating, and reinterpreting program activities (Davis 2007; Kemp and Berkovitch 2019; Mannell 2014; Roycowdhury 2015). Local NGO staff can code-switch, speaking to donors in one way but adapting programs

when implementing them in local communities. For instance, in Heitmeyer and Unnithan's (2015) study of an Indian NGO, local practitioners use the language of 'reproductive rights' to advocate programs to donors, but in implementing community health programs, family planning is mentioned as a minor point within a larger community discussion of gender-based violence. Finally, NGOs can also advocate that their donors enact new interpretations of development problems and adjust their funding priorities accordingly (Cullen 2015).

In the process of translation, NGO workers and the communities in which they work construct new self-understandings. For instance, NGO staff and program beneficiaries in India re-defined their sense of self when responding creatively to state retrenchment. Due to funding cuts, district government agencies no longer had enough employees to process domestic violence cases efficiently. Thus, NGO practitioners learned how to navigate state bureaucracy, teaching survivors to proactively complete the necessary paperwork for officials to file their case and negotiate with the agency. Accompanying this process was a re-definition of the self, as women learned to see themselves not as domestic violence victims, but as their own advocates (Roychowdhury 2015).

The above studies expand our awareness of the power dynamics involved in the translation process as NGO workers contend with local political contexts and donor demands. These studies illustrate the embedded agency of NGO practitioners i.e., the capacity practitioners have to reshape norms and take action within the constraints of their own context (Husain, 2020). Yet, these studies also ignore national variation as they do not differentiate between the types of opportunities provided for agency due to donor differences. Additionally, highlighting agency and resistance, the above research often overlooks a key insight from the decoupling perspective. Sometimes an NGO's practice and policy don't match for reasons that do not involve practitioner agency, such as contradictory goals or a lack of resources.

Therefore, I argue for the need to expand current studies of translation in two ways. First, as discussed in Chapter One, these literatures overstate the degree of homogeneity among international donors and global development programs. As Chapter Two and Three illustrate, embeddedness in distinct national development imaginaries means practitioners in INGO headquarters and donor offices envision different types of programs to support. Thus, as we will see below, local practitioners encounter distinctive programs to translate. For this reason, studies of translation must acknowledge both national variation in programming due to an INGO's

nation of origin and how local practitioners respond to those varying programs in recipient contexts.

Second, in order to theorize how translation occurs in global aid chains we need to attend to the processes of decoupling due to non-agentic forces, translation due to practitioner agency, and the construction of new identities in the translation process. Moreover, we must to be able to analyze these processes across space, as development imaginaries and their resulting program goals travel through multiple organizations in an aid chain. To do so, I utilize the concept of articulation. I draw on articulation as it was employed by Stuart Hall to examine the relationship between race and capitalism, and the varied forms that relationship takes in different historical moments and locations (Hall 1985). Hall points out that conceptions of race and capital do not exist everywhere in the same way. Similarly, as we have seen, development comes to have new meanings in specific national contexts. Hall uses the concept of articulation to understand two processes.

First, Hall analyzes how powerful capitalist and racist ideologies, in different contexts and historical moments, "articulate into a configuration of different subjects, different identities, different projects, different aspirations; it does not reflect, it constructs a 'unity' out of difference" (Hall 1988: 166). For instance, in 1980s Britain, capitalism takes the form of Thatcherism which "encompasses a plurality of discourses – not only about the economy, but also the family, gender, national identity, race, crime, human nature, and so forth – that resonated with, or summoned up one another" (Hart 2002: 28). Racist and capitalist ideologies are effective because they are integrated into pre-existing cultural meanings and institutions.

Second, while acknowledging the power of racist and capitalist ideologies, articulation also examines how the multiple, sometimes contradictory, discourses embedded in an ideology can empower actors and create spaces for agency and resistance, while always operating within the existing structures of a particular context. The concept "enables us to think how an ideology empowers people, enabling them to begin to make some sense or intelligibility of their historical situation, without reducing those forms of intelligibility to their… social position" (Hall 1996: 142).

Drawing inspiration from Hall's work, for my purposes, the concept of articulation can provide insight into first, the power of development imaginaries in aid chains and, second, the importance of the translation processes described in the above literatures. First, articulation acknowledges that a development imaginary is powerful and backed by organizational leaders, resources, and influential institutions (like bilateral donors). Therefore, imaginaries constrain the ways in which actors embedded within them interpret the social world. Nevertheless, imaginaries are made up of multiple and, sometimes conflicting, schema as they conjure up understandings of gender relations, the market, the state, and civil society, which need to be integrated into new contexts when they travel through aid chains. This provides the opportunity for two translation processes described below.

Encountering new development imaginaries and the multiple schemas within them in their own context, provides practitioners with multiple opportunities for agency and translation. For instance, local practitioners might use different schemas against one another. When Japanese INGO staff want to fly in Japanese professors to train local officials, Cambodian practitioners draw on Japanese notions of 'advocacy' as befriending state officials, saying it's too early for Japanese professors to come as they have not yet built strong friendships with state partners. This allows them to, at least temporarily, retain control over INGO workshops. Articulation also attends to the identities and beliefs created or reinforced in the process of encountering development imaginaries and making sense of and/or modifying them in recipient contexts. This process is examined in-depth in Chapter Seven.

Finally, to analyze national development imaginaries and the outcomes of INGO programming, it is necessary to attend to the possibilities of non-agentic decoupling in the process of articulation. Articulation already acknowledges that imaginaries contain contradictory schemas. As national development imaginaries travel through global aid chains, organizations working within them can fall prey to contradictory demands leading to the unintended consequences decoupling scholars aptly point out. Below, I analyze the articulation of distinct women's health programs at HSA and GFA in Cambodia.

Japan's Imaginary in Practice: Health Services Asia's Program Activities

*"*The pregnant woman must learn to eat healthy and listen to the modern doctor." -Boran, HSA program manager

As detailed in Chapter Three, Japanese donor and headquarter organizations emphasize maternal and child health programs that foster an effective public maternal and child health system and promotion of health expertise. Alongside this, there is a rejection of gender equality programming. Donors and headquarters staff argue programs directly addressing gender relations intervene in a nation's culture, something Japanese aid should not do. Therefore, HSA programming is geared towards supporting state implementation of maternal child health services.

During my ethnographic time at HSA, the term gender is never mentioned. The topic of gender, or other terms associated with it commonly heard in Western INGOs (power relations, women's empowerment, men and women's roles in the household, or sex-based discrimination), do not arise organically in a single conversation. Yet, despite this lack of explicit attention to gender, HSA programs geared towards women and newborns display implicit gender assumptions all the same.

HSA program activities emphasize first, educating public health officials, and next, mothers living in rural areas in biomedical information about maternal and infant nutrition. HSA staff describe their work as the promotion of the "modern Asian mother," drawing on regional development rhetoric that assumes Japanese and Cambodian mothers have more in common with each other than with their Western counterparts. The modern mother and her use of scientifically supported solutions is juxtaposed to the use of "traditional" medicine. A program manager, Boran, explains this to me, showing me the Cambodian Ministry of Health's policy on the "modern family." He tells me HSA is helping the Ministry implement this policy here in Stung Treng province by "trying to change the low people's concept." He goes on, "Many village people believe in 'kru khmi' (traditional healers), 'chmop boran' (traditional birth assistants), and magic. If the healers say give your child sugar water, they will do it… but the modern mother, she gives nutritious food only to the child."

Overhearing our conversation, HSA's Japanese director, Junko chimes in, saying this is particularly a problem if the "yay" (grandmother) has a lot of influence over the mother. Boran agrees, telling me that "even if we teach the mother the right way, the yay might say 'no, you must do it the way it has always been done, the way it was when I had children.'" Thus, in conversations with Japanese staff, HSA staff disparage traditional remedies for the power of biomedical knowledge surrounding women's health.

HSA imparts scientific knowledge about maternal and child health by implementing its programs through a "training of the trainers" model. HSA's training of the trainers aims to aid multiple levels of the health system to provide quality care and health education. To do so, HSA employs three male medical experts as 'program managers,' charged with building relationships with state health officials and six 'program assistants' to assist them these activities. Then, Japanese staff are required to submit reports to JICA qualitatively detailing the completion of these training activities and listing the number of officials and women trained.

In the training of the trainers' model, first, HSA staff collect data on newborns, mothers, and pregnant women. Before beginning their work in Stung Treng, HSA conducted a baseline survey on the topics of maternal nutrition, child nutrition, sanitation, maternal health center visits, and birthing practices. Additionally, they continuously collect data on maternal and child nutrition at community health trainings. Program managers then share this data with provincial and district level officials. Male managers and health officials meet to discuss how each districts' health outcomes can be improved. For instance, at a planning meeting, Boran and Samnang describe this data to government officials in great detail. Comparing the numbers to the national average, the men discuss the outcomes that require improvement in their province and districts. Strategies offered include educating mothers and pregnant women, improving access to nutritious foods, and ensuring health clinic workers are offering the correct advice.

HSA staff also support the same district and provincial health officials' health education skills. To do so, HSA staff go to the provincial health department to meet the provincial director of maternal and child health, Dr. Kim, and two district health officials, Dr. Mao and Ms. Channy. There, we rehearse for the health education workshop for the next level of training with health center workers and CCWC officials. Using a flipbook with pictures of different stages of pregnancy and photos of different foods, Dr. Kim is charged with providing a lecture on proper nutrition for newborns, pregnant women, and new mothers. He explains basic food groups, what pregnant women should eat, the risk of anemia, how long breastfeeding should last, and what foods children need to eat from six months to two years of age. Next, Dr. Mao provides information on the frequency of health care visits expected during and post pregnancy as well as the importance of health center delivery. Finally, Ms. Channy describes in detail how to breastfeed and train participants in how to cook "baw-baw grung," a healthy meal of rice

porridge and vegetables for babies. Ms. Channy and Dr. Mao receive updated health information and advice on their presentation from HSA staff and Dr. Kim.

After the workshops for provincial and district level health staff are complete, HSA supports a two-day workshop for health center and commune officials at their Stung Treng office. The participants are approximately twenty male health center workers, two female midwives, and three female Commune Committee for Women and Children (CCWC) officials. Dr. Kim and Dr. Mao present the health education trainings rehearsed in the previous workshop, interspersed with breaks for games and food. One the second day, Ms. Channy presents her information on breastfeeding, giggling at the task. Then, she facilitates participants as they practice cooking baw-baw grung in small groups. Each group gets ingredients and a single gas stovetop on the floor. Male participants mostly sit or stand around, joking with one another. Older women take charge of each group, opening the recipe book, cooking the baw-baw, and younger women help chop and stir. Finally, after the baw baw is made, one woman from each group comes up to present their baw-baw. Per HSA's agenda, biomedical information about maternal health and child nutrition is imparted at this workshop. Yet, the process of dispersing the information is implicitly gendered. Male doctors provide scientific knowledge while Ms. Channy instructs participants on "women's issues" like breastfeeding and cooking. Then, female participants are expected to do the majority of the cooking.

After the above workshop, with the support of HSA staff, health center workers and CCWC officials provide health education and cooking training to village health volunteers at multiple two-day workshops in different districts. There is typically one male and one female health volunteer for each village, but as program manager, Samnang explains that HSA largely works with female volunteers due to the subject matter of its programs. At this workshop, similar to the one above, health center workers, HSA male program managers, and provincial and district doctors provide education on medical knowledge, including pregnancy length, nutrition, clinic visits, and antenatal vitamins. Then, female CCWC officials describe the process of breastfeeding and run the cooking training.

Finally, at the end of the "training the trainers" process, HSA supports health center workers and village volunteers in leading cooking trainings and health monitoring community events in each of the villages in their districts. Nutrition events include the cooking trainings described above. Health monitoring events feature health center workers and HSA program

coordinators measuring the height and weight of infants and pregnant women. At each event, health center workers and HSA staff direct village volunteers in the appropriate topic to cover that day, including a small lecture about breastfeeding, health clinic visits, or appropriate nutrition for babies and/or pregnant women.

At a village health monitoring event I attend with HSA staff, about twenty new mothers or pregnant women are in attendance, waiting under the shade of the village's wooden meeting pavilion. We begin the training. A health center worker and HSA program assistants cajole babies onto scales, speak to mothers, and record information on each woman and child, both in HSA's database and in each woman's JICA-branded maternal child health handbook. Two groups of women will receive a later visit from HSA staff. Mothers of children who are underweight, and pregnant women and new mothers from the village who are not in attendance. Often this is because they needed to work in rice fields or to forage in the forest with their baby on their back.

As children are being measured, the HSA program manager in attendance, Samnang, along with a health center worker, coach the female village volunteer on what to say to the mothers, showing her the flipbook and quizzing her on appropriate diet and breastfeeding for children between six and eight months. She responds to their questions shyly, carefully calling both men "lou kru," or "teacher," a title used to show respect in Cambodia. After the health monitoring is complete, the volunteer nervously speaks on the topic of breastfeeding and nutrition, giggling nervously and looking back at the Samnang and the health center worker for approval. The men watch nearby as she goes through her information quickly. After the ten-minute lecture the women all clap and cheer, congratulating her on completing the difficult task of speaking on scientific information.

Listening to their conversations during and after trainings, beneficiary mothers have mixed responses to HSA trainings. For instance, waiting in line to receive soap after the completion of the community event, mothers talk and laugh amongst themselves, sharing stories about the village, their children, or discussing HSA practitioners. One group of mothers discuss the topic of the training. A mother explains that her mother told her breastfeeding should be done for a different amount of time before giving solid food and another says she has heard babies should have water at times. Another woman motions to Samnang and the health center worker, saying we must try to do what the "kru bat" or medical professionals say. Yet, one mother scoffs

at the training, saying it is a great idea to feed children all those nutritious foods, but who can afford it? And, if they did have the money, her husband would buy meat. Finally, a mother warns them, you have to keep up your child's weight like the book says, pointing to the Maternal and Child Health monitoring booklets each woman has; otherwise health center workers, HSA staff, and even district officials might come to your house and embarrass you in front of the village. Clearly, village women believe such house visits are a negative reflection on mothering skills, and thus, to be avoided. But, notably, while before and after they chat amongst themselves, during training, the women are largely silent.

HSA's Programming & Gendered Articulation

The program activities above, constructed in interactions between Japanese staff in Tokyo and Cambodia, promote non-intervention in gender norms and public health system support. This has unintended gendered consequences in Cambodia. The Japanese imaginary articulates within the interests of Khmer practitioners and state officials. As we can already begin to see above, HSA's silence on gender equality and the regional rhetoric of Asian mothers that utilize modern medicine ends up reinforcing household gender relations. Focusing on health expertise, HSA's programming does not address the assumption that mothers are the main caregivers of children and responsible for family cooking and nutrition. Junko explains their essential goal is to "educate the mothers" who "don't know how to feed their children and themselves nutritious food." The outcome of these assumptions is that only mothers attend community workshops. Thus, HSA misses the opportunity to educate male caretakers.

Lack of discussion around gender does not mean Japanese staff did not challenge gender norms in other, less direct, ways. For one thing, all of the Japanese staff leading HSA are female. Despite increasing female labor force participation rates in Japan, Japanese women are still more likely to work part time or temporary jobs and quit full-time work to become mothers (Shambaugh and Nunn 2017). Additionally, less than 1 percent of Japanese citizens live abroad (compared to 3 percent of U.S. citizens) (Ministry of Foreign Affairs Japan 2017). By leaving Japan to work in upper-level management position in Cambodia, HSA's expatriate staff bucked traditional gender roles in their own nation. Their rationale for doing so will be discussed in more depth in Chapter Seven.

Furthermore, Japanese staff did notice the gendered dynamics at play, particularly in the division of labor during trainings. At the cooking training, Japanese intern, Hanako laments that

'not everyone is learning.' Yet, actions I would have directly said were the consequence of gender roles, such as managers requiring female officials to conduct cooking trainings, Junko and Hanako attributed to "Cambodian hierarchy" or "male staffs' lack of management skills." Junko does inform her program managers, Boran, Samnang, and Sovann, that all health center staff should participate in the cooking training. Yet, such directives go largely ignored and Japanese staffs' unwillingness to discuss gender roles directly made change difficult.

HSA's Khmer program managers actively promote traditional gender norms in programming for two reasons. First, as I will elaborate in Chapter Seven, HSA's program managers do express strong "traditional" beliefs about the roles of men and women in Cambodian society in their personal and professional lives. For instance, when I ask Boran which caregiver was interviewed during HSA's baseline survey, he looks confused, stating "In Cambodia, it is the mother who should take care of her child." Or, when I ask Sovann why men are not invited to the village cooking trainings or health monitoring, he laughs, explaining these topics are "for the woman." Therefore, while Japanese staff refuse to directly discuss gender, Khmer program managers express commitment to traditional gender norms and reinforce them in program implementation. Two Cambodian Global Family Aid staff members hold similar beliefs, but they are well aware it would be frowned upon to express or act on them in their work environment.

However, traditional beliefs alone are not the only reason HSA's programs promote only politically neutral women's health activities and assume will women take on the majority of childcare and household duties. For instance, at HSA, there is also no discussion of reproductive health, family planning, menopause, or women's health outside of childbearing. One day, at a village health volunteer meeting, one volunteer asks HSA program managers about a discussion of family planning at their community health events. Junko responds tentatively, "maybe we can inform them that spacing births is necessary for good maternal health." But, Sovann quickly rejects the idea that even a blanket statement such as this should be made at their events, demanding that birth spacing is a "difficult topic" and outside the scope of HSA's project. Khmer program managers directly and swiftly rejected discussions of topics like reproductive choice or father's involvement. Program managers are also unwilling to take up any topic that might be deemed mildly political, such as women's reproductive choice, because they worry it

might threaten their friendships with state officials in HSA's partner agency, the Provincial Health Department.

To build strong relationships with male health officials, HSA's program managers are all older and male. Program managers are motivated to build positive relationships with state officials for two reasons. First, because it is actively encouraged by HSA's director, Junko and will make state officials more likely to cooperate with HSA programs. Second, managers have their own motivations for wanting smooth cooperation with government staff as HSA program managers espouse career ambitions to move into the Cambodian state in the future. As we will see in the next chapter, this has a positive impact on HSA's relationship with the Cambodian state.

In articulation, the Japanese imaginary and its resulting program activities, which promote state development and ignore gender, stimulates an alliance between HSA staff and public health officials. HSA staff do not just reinforce traditional household gender norms; they also uphold the masculine monopoly on medical knowledge and the hierarchy of the public health system. The Cambodian public health system is a male dominated space. Although, the share of female general public health staff is increasing, men dominate the leadership positions in the Cambodian public health system. The system is also highly centralized and hierarchical, meaning those in positions of power have great influence over the staff they oversee (Frieson, et. al. 2011; H-EQIP 2018). The majority of Cambodian medical doctors are male, creating a near gender monopoly on medical knowledge.

One day, I travel with Samnang and Boran to visit Dr. Kim at his office. The three men discuss why pregnant women lack diversity in their diet. They consider access to particular food groups, such as legumes, and financial barriers. However, both Dr. Kim and Boran agree that one of the most important issues is low health knowledge. Boran states, "The village mothers and the volunteers that help them lack knowledge and often use the traditional methods. They need to listen to doctors and health center workers and improve their diet to help their baby." Women's limited knowledge is determined by the men to be the largest barrier to improvement of maternal and child health, ignoring factors like access to food, financial constraints, or resistant husbands. After the meeting, I am dropped off at the provincial health department's small library since a woman, even a foreigner, does not need to be present for male bonding rituals; Boran and Samnang head to the courtyard of the health department to play Ping-Pong with the vice

provincial health director, part of an effort to bolster their relationships with the provincial officials.

On the way back to the office, Samnang looks pleased, he explains to me that it is good for HSA staff to have positive relationships with higher-level provincial officials. Program managers and state officials work together to improve maternal health while preserving masculine authority over biomedical knowledge. Therefore, in an alliance with state officials, program managers reinforce the hierarchical public health system (where they hope to have a career in the future) and male medical authority over women's bodies and choices. Thus, the Japanese development imaginary envisions a strong public health system, but activities implemented to achieve this vision are articulated via gendered beliefs and the career ambitions of Khmer staff as well as the pre-existing organization of the Cambodian health system.

However, one final outcome of this articulation process must be noted. HSA and government health staff also work together to strategically shift the content of HSA's trainings, determining it makes more sense to discuss traditional health practices. Sovann explains, "It does not work just to tell them the traditional practices are bad." In practice, HSA staff help government officials promote a hybridization of biomedical and traditional healthcare, even as they disparage traditional practices in front of Junko and other Japanese staff (Decoteau 2013). For instance, when asked by a village health volunteer about whether or not women should go to see the Kru Khmi (traditional healer), Samnang encourages her to tell women it is not a problem to see the Kru Khmi as long as they see "the modern doctor" first. Furthermore, it must be noted that I often saw HSA staff themselves utilizing traditional cures, such as teas made by traditional healers or cupping[17]. Thus, while the majority of health education focused on biomedical maternal and child health information, HSA and government staff agree it is not effective to reject or ignore traditional practices in village trainings. This articulation is made possible by the close relationship between HSA staff and state officials, an opportunity GFA does not provide.

The U.S. Imaginary in Practice: GFA's Program Activities

"For us, gender is a cross-cutting issue. We must think about it in all our activities" -Ranny, GFA's director

[17] https://www.webmd.com/balance/guide/cupping-therapy#1

As illustrated in Chapters Two and Three, the Japanese imaginary - and resulting aid chain - is more centralized than the aid chain that originates in the U.S. HSA staff focus on a single goal: upgrading public maternal and child health services. In contrast, Global Family Aid (GFA) needs to implement the multiple goals embedded in the U.S. imaginary, including state partnership, promoting the private health sector, and supporting grassroots organizations. Thus, GFA cultivates relationships with the public, nonprofit and private sectors. Specifically, to support the nonprofit sector, GFA constructs and monitors programs implemented by local NGO subgrantees. The larger number of goals and actors in the U.S. aid chain makes its articulation more multifaceted than HSA's. I describe below the activities of GFA's country office and implementing partner organization, Cambodian Development Society (CDS).

As the above quote shows, at Global Family Aid (GFA), gender is considered a "cross-cutting issue" and staff aim to integrate it throughout all of their health program activities. In contrast to HSA, at GFA's country office discussions of gender are relatively frequent. To start, per its gender implementation policy,[18] USAID requires all INGO sub-grantees to conduct a gender analysis before program implementation can take place. In the gender analysis, INGOs must research gender norms and power relations between men and women in the project's context and how these might affect project activities. Then, they must develop a plan of action for integrating gender throughout the life of the project. In its plan, GFA commits to gender activities in programming such as male integration in family planning, maternal health, child nutrition, and WASH[19] programming in order to challenge unequal household labor norms. Additionally, it will support women's leadership in communities and health education. GFA will also host a gender workshop for the staff of GFA's government partner, the Cambodian Center for Health Communication (CCHC), include gender sensitive indicators in its monitoring and evaluation, and provide gender workshops for GFA staff and local implementing partners.

The market logic of the U.S. development imaginary prominently enters into GFA's gender activities. Its program promises to improve women's health services on the "supply" side, working to upgrade the services provided by private clinics and cooperating with its government partner to better regulate private and public clinics. The project also emphasizes the "demand" side by examining women's barriers to access to healthcare and supporting local NGOs in

[18] https://www.usaid.gov/sites/default/files/documents/1870/205.pdf
[19] Water, Sanitation, and Hygiene programs are commonly referred to as WASH projects.

addressing them. For instance, in a meeting, the project team considers how to improve child and maternal nutrition; GFA's director, Ranny, chief of party, Dr. Benilda, and deputy director, Erin, discuss barriers to changing eating habits, including financial need, geographical access, but also the support of husbands and in-laws. Ranny points out it is necessary to educate fathers on maternal health and nutrition as well. She says that in a previous project, fathers blocked women from seeing doctors because they were paying. She argues that by educating men, women can become better healthcare consumers and this must be included in health programs. A discussion like this one, of gender and power relations in the home and how they shape maternal and child nutrition, never took place at HSA.

GFA staff also often include the topic of gender equality in their many meetings and workshops, at least briefly. GFA holds collaborative meetings with government officials from their partner ministry and public workshops with other development practitioners in Phnom Penh. For instance, GFA hosts a half-day development community workshop on improving health education projects in Cambodia. At this workshop, one slide is included about the importance of addressing gendered dynamics in health behavior change activities and approximately five minutes are spent discussing the subject.

However, as the above example suggests, gender is just one of numerous USAID requirements and objectives that GFA staff are trying to pursue, alongside a relationship with the Cambodian state as well as monitoring private clinics and local NGO implementation. Per its agreement with USAID, GFA also needs to work private, public, and nonprofit health actors to create what they term a health behavior change community of practice in Cambodia and fund national health campaigns. Not to mention staff must also write English reports and track budgets in great detail for all of these activities. While GFA does maintain a larger staff devoted to this USAID project than HSA's JICA project, it is not substantially larger. GFA maintained 14 full time staff for the USAID project, including the director who spent substantial time on it, as compared to HSA's 10 full time project staff.[20]

GFA's Programming & Gendered Articulation

[20] Both organizations could pull in technical assistance from headquarters. However, GFA had substantially more resources and people within the organization and headquarters who could provide assistance if needed due to being a larger organization.

Due to the above reality, though a number of GFA staff members wanted to transform gender relations by integrating them fully into programming and evaluation, in practice, gender as a cross-cutting theme meant that challenging gender relations is often pushed to the backburner among the variety of other activities staff need to accomplish. Furthermore, GFA project staff display varying levels of commitment to changing gender through programming. For instance, GFA's communications manager, Srey-na, considers herself a feminist and contends that programs must challenge household gender roles to improve women's reproductive choice. Dr. Belinda also argues for the need for program to empower women to make choices, although she doesn't think GFA needs to work with men. In contrast, M&E specialist, Panh argues that he does not really think it is possible to change gender roles in Cambodia, or that GFA should try to do so, but he knows they need to do these activities for their donor. Staffs' personal gendered beliefs will be further discussed in Chapter Seven.

Due to the varying gendered beliefs of GFA staff and the number of activities staff are required to implement, GFA displays an uneven commitment to its goal to challenge and transform gender relations in Cambodia. In an example of non-intentional decoupling, in articulating the gender empowerment goals of programming, even GFA staff committed to challenging gender inequalities face a gap between aspirations and time allotted to achieve them and simply need to be pragmatic about what they can actually get done. Thus, the integration of gender into GFA's activities is uneven.

Similarly, in workshops and interactions, GFA's government partner, the Cambodian Center for Health Communication (CCHC) exhibits mixed perspectives on the topic of gender. Some younger female doctors tell me they are excited that things are changing and that CCHC's new director is female. In contrast, at a CCHC workshop on health behavior change data, when the topic of gender arises an older male staff member responds in an annoyed tone, arguing that concern with gender is a foreign imposition, shutting down further conversation. He states, "In our culture these days, woman is king, foreigners have pushed for women and men to be equal. There is no more difference between men and women because foreigners have pushed this on our Cambodian culture." Interestingly, I later learned that this same male staff member had participated in a JICA training for Cambodian officials, traveling to Japan in the early 2000s to study public health promotion. GFA tries to contend with such beliefs in the gender workshop it

will provide to its own and CCHC staff, but changing long held opinions with the one gender workshop that the project plan calls for is a near impossible task.

As suggested by the example of the staff meeting described above, GFA staff design and monitor specific gender activities to be implemented by local NGO sub-grantees. However, it is largely GFA's local NGO subgrantees that implement GFA's programs directly. Thus, we must investigate the practices of the Cambodian Development Society's (CDS) health team in order to fully comprehend the articulation of GFA's programming.

The U.S. Imaginary in Practice Continued: Cambodian Development Society's Activities

"We disperse health information and we help young women and mothers with too many children use modern birth control." – Reasmey, CDS health team leader

Global Family Aid (GFA) provides a grant to Cambodian Development Society (CDS) to implement GFA's maternal health and family planning activities in Kampong Speu. In doing so, GFA recreates a very similar relationship with CDS to the one it has with USAID. It calls for proposals from local NGOs in the area and after CDS wins the project, GFA and CDS enter into a contract, which details the specific activities CDS will implement and the measurable outcomes that will be produced. CDS will provide health education on family planning and maternal health targeting women of reproductive age including young recently married women, pregnant women, new mothers with children under two, mothers with more than four children, as well as women who do not use birth control or employ 'traditional' family planning methods such as withdrawal. Activities will also be included that challenge the understanding that maternal health and family planning are solely the issues of women, such as educational workbooks depicting 'happy couples,' and education events that incorporate husbands and male community members. The U.S. imaginary influences the program activities CDS staff encounter in three important ways. I describe each below.

First, there is an emphasis on women's empowerment in the labor force. U.S. programs often integrate maternal and reproductive health activities under the logic that mothers can control their reproductive capacities and return to work. The contract between GFA and CDS includes aspirational gender rhetoric, noting the importance of empowering women to work through reproductive choice and incorporating both men and women in programming. These ideas challenge norms that maternal and reproductive health are women's responsibility. The

project agreement also includes a clause encouraging health staff to integrate marginalized women and women that face barriers to healthcare access, such as disabled, HIV positive, Cham Muslim, or very poor mothers. Second, market logic shows up as the individual empowerment of women's health consumers. In the proposal, CDS is portrayed as augmenting the 'demand side' by encouraging women to visit clinics and uptake modern birth control methods. CDS staff are training women to "advocate for their health"[21] and bring consumers into the healthcare market. GFA's measurement plan then flows from this directive to increase the number of maternal health consumers, evaluating CDS's work to expand demand in the healthcare market.

Third, the contract has clear guidelines for efficient monitoring and evaluation, outlining how success will be measured and how the effective use of funds will be determined. CDS staff must carefully count the number of women served, and GFA staff visit to check these numbers quarterly. In the past, U.S. development programs have been criticized for focusing on counting the number of women trained as an indication of success, failing to provide evidence of health behavior change. Thus, GFA wants to address this problem in its contract with CDS. As a project goal, CDS staff will work to "increase accessibility and referrals to…services in the public health facility, private clinics in GFA's quality health network and NGO clinics." CDS health team members are trained in health behavior change communication and provided with referral slips. Successful referrals are measured by the number of pre- and postnatal care visits and uptake of modern birth control.

In implementation, there are two outcomes of CDS's programming as staff articulate it in the Cambodian context. First, generally CDS staff strategically choose to promote female choice, even when to do so they must subvert the contracts directive to engage both male and female partners. Second, CDS practitioners are constrained by quarterly monitoring reports. Each outcome is depicted below.

CDS Programming & Gender Articulation

Outcome 1: Female Choice.

To observe program implementation, I travel around Kampong Speu province with Reasmey, the leader of CDS's health team. Reasmey runs a team of twelve health staff members: eleven women and one man.[22] When she's not completing

[21] This is in contrast to European-funded women's health organizations I interviewed, which reported creating women's health advocacy groups

[22] At the first team meeting I attend, the male staff member, Kheng, quickly wants to explain to me why he is the only man teaching about women's health, which many consider a "woman's job." Jokingly pointing out how he is a

paperwork in CDS's office, Reasmey travels by moto, often for hours into the countryside, to observe the work of health team staff. Each health team member is in charge of a target area of approximately three or four communes. Most team members live with their families in a village within their assigned target area. For the most part, each health team member's time is spent getting to know people in the villages within their area and training small groups of women on maternal and reproductive health. In contrast to HSA, where staff conduct some limited village mapping but mainly count on village health volunteers to gather information about target participants, CDS staff spend a lot of time building relationships and gaining information about women of child-bearing age in the villages themselves. Most team members work with approximately twenty villages. It was necessary to 'map' each village in order to identify target women for training.

One day, I went with Reasmey and her health team member, Sotarath to complete a village mapping. When we arrive, Sotarath is in conversation with her uncle's friend and his wife, who live in the village. Health team staff often build relationships with villagers via personal networks. Based on informal discussions with villagers, Sotarath is drawing a map of the village. It documents access to water, rice farms, and nearby health centers. Each house in the village is drawn with descriptions of the women that might need health education. Next, we go to visit another acquaintance of Sotarath. She fills us in on her neighbors, reporting to us women who have more than four children, and who recently had a baby, identifying those who travel to Phnom Penh for factory work (a group considered in need of reproductive health information). After this, we go to visit the village chief. We lay out the map for him and he adds information to it, suggesting we visit one woman with five children who lives on the outskirts of the village.

In addition to mapping communities, health team members conduct health trainings. Trainings take place in women's homes and often include no more than five friends and/or neighbors. One day, I travel with Reasmey to a village approximately an hour and a half away from the provincial capital. We wind slowly down bumpy dirt roads on motos until we find Reasmey's team member, Chantou, waiting for us in a hammock at her aunt's home. After we arrive, we eat lunch with Chantou's family, and Reasmey makes inquiries about their opinion on the village's needs. After this, Chantou takes us to observe her health training. We visit a mother,

man among many women -- he tells me he has kept this job for twenty years and the health team previously worked on HIV. After HIV funding declined, CDS's health unit shifted to family planning and maternal health.

who cannot be more than forty-five herself, and her two adult daughters. One daughter recently had a baby and the other is pregnant. We sit in the shade of the space beneath their wooden house on a bamboo platform. Two other neighbor women come over to listen as well, one with her own toddler and baby in tow. The babies sit looking at each other, getting jostled on their mother's laps. The mother of the house listens while weaving at her loom.

First, Reasmey and Chantou get to know the women a bit, inquiring about their families and holding their babies. Then, it is time for health education. Reasmey and Chantou get out their colorful pamphlets and pass them around. One boasts pictures of breastfeeding mothers and pregnant women at the health clinic. The other presents photos of different medical birth control methods. First, Chantou asks the women if they know how many times pregnant women and new mothers should visit the clinics for pre and post-natal care, what pregnant women should eat, and how to breastfeed. The pregnant woman says it is hard to go to the clinic for a checkup because she needs to work. Chantou and Reasmey respond that they will help her talk to her husband and Chantou can drive her to the clinic. Reasmey exclaims, "I am sure your husband wants a healthy baby!" Unlike HSA, foreign staff at GFA recognize it is not possible to provide only biomedical information to mothers. CDS staff are encouraged to discuss traditional practices. They discourage a few harmful ones, like the practice of roasting, where newborns and mothers sit over hot coals. But, other practices, such as prayers or offers to ancestors or spirits are encouraged alongside medical care.

Next, Chantou asks the women if they know how soon after giving birth a woman can get pregnant, inquiring about the family planning methods they use. One mother says she has tried the pill while the rest of the women say they use traditional methods. After that answer, Reasmey and Chantou look at each other skeptically, and Reasmey launches enthusiastically into family planning education. She uses a happy couples booklet to discuss the need for family planning with husbands, explains each of the 'modern' methods including the pill, the implant, the shot, condoms, and then, takes extra time to promote the IUD. While GFA strictly adheres to USAID's rules to promote all methods equally in program construction, CDS had a previous project with a different donor in which the health team specifically encouraged IUD use. For this reason, it is the modern method with which team members are the most familiar.

After Reasmey and Chantou present the types of medical birth control, the participants look overwhelmed by all the information and nervous to be discussing the topic of family

planning. The neighbor laughs apprehensively. One of the daughters expresses confusion. Reasmey and Chantou continue to discuss the benefits of modern methods with the women. They present the women with a chart that shows how often withdrawal fails versus modern methods. Two of the women share stories they have heard from other villagers. One mother says her friend used the shot and it made her gain weight. Reasmey says this is possible, but that is why the non-hormonal IUD is better. The mother of the house chimes in, saying she tried the pill once but it made her gain weight and gave her hot flashes. Reasmey responds to this concern by explaining the hormones in the pill have been updated since that time. The pregnant participant says she has heard the IUD can make you infertile. Reasmey expalins she has heard this too, but it is a myth, stating "sometimes we listen to hearsay but it is better to listen to the midwives at the clinic."

Then, speaking quietly, the neighbor expresses her anxiety about the number of children she has. She tells Chantou she has three children and she doesn't think she can afford to have more but her husband does not want her to take birth control. Reasmey says this is another good point about the IUD. "There is a private aspect to it" and "no one but you and the provider have to know anything about it." Chantou supports this, explaining it will work for years, the husband will never know about it, and it can be removed at any time. After discussing their questions, Reasmey and Chantou quiz the women, asking them questions like "what are the modern methods?" "How many prenatal visits to the clinic should pregnant women have?" To conclude the visit, Chantou provides the women with referral slips to visit the nearby clinics and promises to visit them again in a few weeks. After the women disperse, Chantou speaks quietly to the neighbor, asking if she wants her to take her to the clinic when her husband is out of the house. As the above example shows, while GFA aspires to include husbands and wives in discussions of family planning, in practice, health team members sometimes tactically aid women who want to utilize medical birth control without their husband's consent.

CDS's health team members are deeply aware of the needs of the communities they serve. Health team staff are largely women and come from the surrounding community and express to me a desire to improve women's lives in their own communities. They discuss health information with small groups of women, getting to know beneficiaries personally. Due to the U.S. imaginary and resulting women's health programs alongside the social location and goals of practitioners, this articulation looks very different from HSA's. It does little to support public

health services. However, it does not reinforce the power hierarchy of male state officials as does HSA's health education model. Of course, there are power dynamics between the female trainers and participants. NGO workers are widely considered more educated and well paid than the average villager, commanding a certain level of respect. Yet, it is not the same level of esteem given to male health experts and health center employees, in front of whom village women feel obligated to act formally. As GFA's project goals and CDS practitioner interests meet, in its articulation, CDS's small group model allows health team members to create personal relationships with villagers, women have intimate conversations about difficult topics, and mothers are provided with choices about their reproductive health. This is not just a transfer of government sanctioned maternal and child health information. Relationships are built between participants and staff, and health staff follow up with trainees to encourage health behavior change.

In addition to village mapping and small trainings, CDS health staff need to conduct large community health workshops at least once per quarter. At health education workshops, two health team members from nearby target areas work together with village health volunteers to gather between twenty and forty participants in an area. Then, all of the health volunteers as well as upper-level staff from CDS provide this larger group with similar health information as in smaller trainings. At events, pre- and post-natal care are described, health team members perform entertaining skits about breastfeeding, and all the types of medical birth control are discussed. After information is dispersed, participants play quiz games and those that can answer questions about maternal and reproductive health correctly are given prizes, such as t-shirts and notebooks with GFA logos. At the community health education event I attend, there are about twenty women and one male in attendance. Reasmey tells me it's more difficult to get men to attend these events since they need to work during the day and the topic is considered a 'women's issue.'

Yet, as required by GFA, CDS also holds 'happy couple' events in which couples present their experience sharing decision-making about family planning and maternal health. Reasmey explains that happy couple events, which include both men and women, are held less frequently and often later in the afternoon. 'Happy couple' events are also difficult because it is not so easy to find two couples willing to talk publicly about family planning, since it is seen as a "women's issue" and a "difficult topic" to discuss openly. She says that to implement more happy couple

events, GFA would need to provide more support so events could be held in the evening. To do so, she would need to pay health team members overtime for working at night and provide dinner to attendees. In practice, outside of required happy couple events, when men come up during intimate trainings, they are often waved off by the trainers and trainees or run away as soon as they hear 'women's issues' being discussed. A health team member, Chantou, further explains that it is easier, private, and more comfortable to have female-only conversations.

Thus, in its articulation, CDS's implementation maintains a firm focus on women. Reasmey informs me she believes women should have a choice in family planning; this is very important. She encourages women to "take power on this issue" and helps them convince unwilling husbands on matters such as clinic visits or modern birth control. But Reamsey is also aware that changing men's perspectives will "take a very long time" and women in the communities need to solve their family planning problems in the present. Despite rhetoric that men and women should be involved, in practice, the CDS health team strategically determine that in the current context, it is more pragmatic to focus in on supporting women in gaining information and making their own reproductive and maternal health choices.

Reasmey also tells me, in her own family, she feels the duty of birth control should fall to the wife "since she is the one who can get pregnant." She goes on to tell me condoms are only for the man to protect his family. She states, "sometimes the wife, we are tired, we cannot please him so he would go outside but he should also protect himself not bring any disease into the family or let the community know of his actions. That is how to be a good husband." Reasmey's statements about her personal life mirror the project's articulation, as its meanings are shaped by the constraints of local context. She believes deeply in female choice but finds it more difficult to challenge male power. Thus, unlike at HSA, staff at GFA and CDS do directly address the need for women's empowerment and female choice, addressing the 'difficult' topic of reproductive health. In implementation, CDS's program does promotes female choice about and access to reproductive health services for many women. However, despite rhetorical commitment to gender equality, CDS staff do feel they have the time or resources needed to confront unequal household relations, and must decide to do what they can to improve the lives of women in their communities.

Outcome 2: Evaluation Contradictions. In the previous section, I described CDS's routine activities involved in program implementation. However, as noted earlier, CDS staff success is

measured in the number of women they educate as well as medical birth control uptake and number of prenatal visits attended. Here, I will discuss how practices shift at CDS as quarterly evaluations draw near. As described in Chapter Two, in the U.S. imaginary, modern birth control uptake is seen as a way to empower women. With it, women can make their own choices about childbearing and working outside the home. Furthermore, USAID has been promoting measurement in development since the 1960s (Krause 2014). In competition for funding with the private sector, it is considered an essential way to ascertain whether funds are being used effectively and illustrate organizational expertise. This narrative makes sense in the U.S. context. As these practices travel through the aid chain to Cambodia, they compel GFA's Phnom Penh office to vehemently measure the implementation of reproductive health programming. Then, as the time for quarterly evaluations draws near, CDS staff feel pressured to increase the number of women who uptake modern birth control methods.

Each quarter, CDS must meet the required numbers to continue to get funding from GFA, and thus, since NGO work is often grant dependent, for health team members to continue their employment. While some pressure is necessary to convince women to go get maternal health checks, it is generally not very difficult. Health team members work around women's work and time constraints, provide rides to the clinic, and convince other family members. However, particularly as the quarterly review approaches, GFA's measurement system for birth control uptake can lead health team staff to place strong pressure on women from villages to use medical birth control. To be clear, this is not to say that many participants do not want to use medical birth control. Some participants are happy to have the information and seek out medical birth control after getting a referral from CDS's health team. CDS's activities provide many women with access to reproductive health knowledge and care. However, the number of women who do so of their own initiative is not always enough to meet the target quota in CDS's contract with GFA. When this is the case, health team members find themselves in a position where they need to quickly convince more women to use medical birth control.

Team members use many methods to convince women to use modern birth control, allaying their fears and taking them to clinics themselves. On rare occasion, they also turn to misinformation. For instance, Chantou explains to traditional method users that withdrawal can be 'dangerous' for their husband:

> You, who use the natural ways, do you know the consequences of the natural methods? You don't know? It impacts the health of your husband very much and he does not sleep so well… it is as if you are driving a motorbike that goes very fast, and we go down a slope at a very high speed and there is something that crosses the road and we brake abruptly… we fall, right? His nervous system will be excited, he will have psychological problems after this, it is like madness. He can't sleep and think a lot about it and some men will have weaknesses because he was not able to get things out [ejaculate]. His head and his body… this badly impacts his health. For the hormones in birth control, it impacts your health. But if you use natural ways, it impacts the health of your husband. Do you want that?

Such misinformation can serve to frighten women into using medical birth control to protect their partners.

Thus, four times a year, CDS health team members feel pressured to ensure the correct number of women adopt modern birth control, before GFA staff come from Phnom Penh to check CDS's numbers. Furthermore, about twice a year, for another project working with private clinics, GFA staff come to observe and evaluate midwives at private clinics. CDS staff cooperate with this practice as well. Using their community connections, CDS staff bring in women from the surrounding community to obtain services. Typically, this is not so hard for pre and postnatal visits, although there is some cajoling of women to pause their work or of male family members to get the money for clinic visits. However, GFA medical experts also want to observe technical skills, such as IUD insertion. Thus, health team members must convince at least three or four women in the community to get an IUD on this day.

On the quality check day that I observed, I traveled around with Reasmey and Sotarath. First, we go to pick up a young woman with a toddler and a newborn Sotarath met previously. She immediately comes with us, thanking the women for taking her, and getting in the van after leaving the newborn with her husband and his parents. But, Reasmey informs me we still need at least two women. Most women in the villages are "uneducated and afraid" when it comes to medical birth control. We spend two hours traveling to five different family homes. Reasmey and Sotarath desperately try to convince women to get IUDs. The first woman we visit lives in a rundown shack. She weaves bathmats out of strips of cloth to sell at the local market. She is surrounded by four young children and several chickens. Reasmey tells her about the IUD calmly but the woman says she does not want it. Reasmey tries to tell her she can be empowered by the IUD and take it out at any time but the woman does not want it. Sotarath asks the woman kindly, "please, sister" and explains to the woman why she does not need to be afraid of the insertion or side effects but the woman still says she doesn't want it.

Then, Reasmey speaks with more passion, urging her to look "at her situation," as she points to the shack and her half-dressed children running around in the dirt. Reasmey points out to the woman "you are so poor, how can you want more children?" She persists asking her how she can provide for her kids and "what kind of life they will have?" The woman looks embarrassed, but without meeting Reasmey's gaze and continuing her weaving, she shakes her head and again says that she does not want it. Then, Reasmey tries to convince the woman's father, who is sitting nearby. He says to ask her husband, who is away. After this, Reasmey and Sotarath give up. We go to four other houses, where they try to convince women and/or male family members. Eventually, two other women consent to the IUD insertion. At the clinic, GFA health experts watch as the clinic doctor consults with each woman and inserts an IUD. Then, CDS staff take them home in the van.

Again, I must note, this is not the norm, as quality monitoring days like these greatly exaggerate the pressure for CDS staff to get women to use modern birth control. Nevertheless, these times present a clear case in which the multiple schemas in the U.S. imaginary clash, creating an unintended consequence in articulation. In D.C., family planning education is understood as a path to women's economic empowerment and a way to decrease maternal mortality rates, and good monitoring and evaluation practices will ensure programs are effective and efficient. Yet, when these two practices travel through the aid chain and meet in Cambodia, it articulates in activities that mean local staff feel pressured to compel women to take up modern birth control. In the end, this creates a situation in which measurement goals undermine aspirations to empower women with reproductive choices.

Gender, Imaginaries, and Articulation

Considering Chapter Two, Three, and the above findings together, the analysis of articulation here demonstrates the importance of investigating programs across multiple contexts. Often studies examine a single development organization, typically an international or local NGO, or investigate the types of development programs in large NGO data sets. But, if we turn the unit of analysis, from organizations to programs traveling through aid chains, we can better understand the outcomes of development programs due to their articulation in multiple contexts. Chapter Two and Three illustrated how donors and INGO headquarters are embedded in development imaginaries, meaning they design and monitor types of programs and practices

based on their nation's vision of development. Then, embeddedness in distinct aid chains provides different possibilities for agency as well as constraints for Cambodian practitioners.

Yet, the Cambodian context is not a blank slate for incoming ideas from the U.S. and Japan to move. In their broker role between foreign donors and beneficiaries, local practitioners negotiate and are constrained by distinctive incoming programming activities in the recipient context. At HSA, two aspects of the Japanese development imaginary, to remain gender neutral and pursue strong state partnership in programming, articulate in the Cambodian context with unintended program outcomes. When it comes to gender, Khmer program managers and state officials purposefully use HSA's programming to reinforce "traditional" household gender norms and male power in the public health system. In contrast, GFA's competing program goals mean program staff unintentionally decouple gender equality aspirations from practice, due to time constraints. Finally, at CDS, two contradictory schemas mean that when reproductive health activities that are meant to be empowering female choice articulate with monitoring and evaluation on the Cambodian context, it ends in local practitioners feeling pressured to get a certain number of women to adopt modern birth control.

The method of investigating programs as they travel through aid chains and articulate allows us to simultaneously attend to the power of national development imaginaries, the consequences of contradictory schemas within them, and the distinctive opportunities and constraints each imaginary for local practitioner agency. Imaginaries articulate with recipient contexts in distinct ways, and, occasionally, contradict one another, undermining, supporting, and modifying program goals. In the following chapter, we see how another aspect of each development imaginary articulates in each INGO's relationship with the Cambodian state.

Chapter Six
Divergent Partnerships: National Variation and NGO-State Relations

The gendered program outcomes described in the previous chapter are only one space where the distinctive development imaginaries of the U.S. and Japan have significant consequences in Cambodia. Embeddedness in different aid chains produces divergent understandings of what it means to support developing state capacity to promote public health. This chapter will analyze Japanese INGO, Health Services Asia (HSA) and U.S.-based INGO, Global Family Aid (GFA)'s competing conceptualizations of the state's role in healthcare and argue that one of these visions articulates much more readily into the Cambodian context due to its resonance with the goals of state officials. Whereas HSA centers the government in its conception of the Cambodian health system (the 'state as implementer' model), GFA tends to see the state as having more of a facilitative role (the 'state as coordinator' model). Consider the examples from HSA and GFA staff meetings below to begin to examine each organizations' approach to state partnership.

It's a cool morning in the small town of Sesan, in the northern province Stung Treng, where Health Services Asia's (HSA) provincial office is located. I sit in an open-air, two-room office where the staff is assembled around a large table. HSA's director, Junko, her intern, Hanako, and HSA's three program managers, Boran, Samnang, and Sovann, discuss their strategy for building a successful government partnership. They emphasize the need to identify and befriend an official at the provincial health department, their main state partner, who is higher in the bureaucratic hierarchy than the doctors they already work closely with in their programming. This official will need to have influence to ensure staff from the provincial and district public health offices attend HSA's workshops. Junko and Boran list off different doctors in the provincial health department by name. Boran poses to the group, 'what about Dr. Mao?' Junko wonders if he has the sufficient level of influence HSA is looking for in its government liaison.

When Boran next suggests Dr. In, Samnang expresses skepticism about Dr. In's level of commitment to implementing public health policies. Hearing this, Junko becomes defiant: 'In

response to disinterest, we must make them move just as we did in Kampong Speu [their previous project site]. We can offer support for what they need--conferences, per diems, meetings, and slowly, slowly we will build the right connections." She passionately describes how they will get public health officials to follow the Ministry of Health's (MOH) policy, attend HSA trainings, and implement public health services. "It is their job to implement the MOH policy! Don't they know it is their job?' Junko and her program managers focus considerable energy on making the right connections in the government. Their main goal is to promote public health by supporting provincial health officials in implementing the policies of the Cambodian MOH.

In contrast, at a similar staff meeting at Global Family Aid (GFA), program staff sit around a conference table in GFA's large, air-conditioned multi-story office, located in one of the wealthiest neighborhoods in Phnom Penh. Again, staff discuss successful cooperation with their government partner, the Cambodian Center for Health Communication (CCHC), a sub-agency under the Ministry of Health. GFA aims to help the CCHC create a coordination system. The system will monitor private, public, and non-profit health actors implementing health education or health behavior change[23] activities in Cambodia. GFA's director, Ranny, explains that her staff needs to "help the CCHC be strong." CCHC will illustrate how useful the coordination system is, and then advocate to the Ministry of Health (MOH) for continued funding to sustain this work. When one staff member asks why so many meetings with CCHC are necessary, GFA's deputy director, Erin explains, "we are being paid to get their buy-in for this idea, that's why USAID gives us all this money; we have to convince CCHC that state coordination is useful." Thus, in contrast to HSA, which aids state officials in implementing MOH policies, GFA imagines a new role for its government partner, one in which it will serve not as a public health implementer, but as a coordinator of hybrid health service providers.

How can two similar staff meetings envision such different roles for state partners? In what follows, I illustrate HSA and GFA's distinctive goals for state partnership and resulting program activities. I then detail why HSA' partnership goals resonate more readily in the Cambodian context. However, first, I will briefly introduce the chapter's intervention into relevant literature on NGO-state partnerships.

[23] Health Behavior Change Communication is health communication technique used in international development. https://healthcommcapacity.org/about/why-social-and-behavior-change-communication/

Increasingly friendly?: NGO-State Partnerships

Scholars and practitioners alike often describe NGOs as members of "global civil society," in dialogue with state, corporations, and multilateral organizations on global issues, such as climate change or human rights (Keck and Sikkink 1999; Smith 2008). The United Nations defines NGOs as civil society organizations, or part of the 'third sector,' separate from states and private actors[24]. Yet, while NGOs do sometimes mobilize groups to advocate for social policies or community needs, as we saw in Chapters Two and Three, this is by no means the only way that NGOs interact with the state (Campbell, DiGiuseppe, and Murdie 2019). Recently researchers have problematized the assumption that NGOs are distinctly civic actors isolated from the state or market (Bernal and Grewal 2014; Lichterman and Eliasoph 2014; Sharma 2008; Viterna, Clough, and Clarke 2015). Mercer (2002) explains, "NGO involvement in the politics of development is far less predictable than the liberal democratic view imagines, and…. the contributions made by different types of NGOs to development differ spatially and temporally" (19). Specifically of interest for this chapter, state-NGO partnerships are becoming increasingly common (Brass 2016).

In the past 20 years, development cooperation between NGOs and states has grown more frequent around the world, blurring the boundaries between state and non-profit actors (Brass 2016). State-NGO partnerships are particularly common in the health sector globally (Hushie 2016). Scholars have traditionally assumed state-NGO partnerships would undermine state authority, with citizens assuming their state could not provide social services (Banks, Hulme, and Edwards 2015). Yet, recent research demonstrates citizens often credit state officials with bringing NGOs and foreign donors to their area (Dietrich, Mahmud and Winters 2018).

State-NGO partnerships take various forms. First, NGOs are invited frequently to collaborate in government planning and policy creation, such as in government-run NGO work groups. Second, NGOs often provide educational or "capacity building" workshops to enhance the technical skills and knowledge of state officials (Brass 2016; Lake 2018). Third, because developing states lack the financial capacity to implement welfare services, particularly in remote locations, NGOs subsidize states, filling in gaps in service provision (Banks, Hulme, and Edwards 2015).

[24] https://www.un.org/en/sections/resources-different-audiences/civil-society/index.html

Researchers document how these activities can impact state capacity or the state's ability to effectively implement social services, in sectors such as education or health (Brass 2016). In some cases, NGO programs can support state capacity via organizational isomorphism. Working with NGOs over many years, states may mimic NGO participatory approaches, such as providing public service 'report cards' and accountability tools, like tracking outcomes (Brass 2016). Relatedly, Milli Lake (2018) finds NGOs can be influential in building the capacity of specific agencies, even when overall state capacity remains limited. She illustrates how NGOs and multilateral organizations in the Democratic Republic of Congo are able to aid the government in pushing through laws against sexual violence. Then, combining capacity building and service provision, NGOs support courts in cases related to sexual violence and provide training for court officials. As a result, court officials in the DRC increasingly take up sexual violence cases, enforcing laws in court convictions. Lake compares the DRC to South Africa, where a stronger legal system does not allow international actors the same level of access. Her work suggests that in states with limited institutional capacity, international organizations have more influence over specific state agencies and actors. Yet, in other cases, NGO social service projects can also be co-opted by state officials and integrated into patronage politics (Banks, Hulme, and Edwards 2015; Heurlin 2010). Such varying outcomes are due to the fact that when non-state actors intervene in recipient state agencies, they enter into negotiation with officials who maintain own interests and goals (Li 2015).

Thus, the impact of NGO-state partnerships in developing nations is diverse. Existing research shows the importance of attending to different types of NGO-state cooperation, and the multiplicity of outcomes that result in specific contexts. Previous work emphasizes developing state context as a key factor shaping the success or failure of INGO efforts to promote state capacity. My results do demonstrate that developing country context is a key explanatory factor. However, I argue the above literature does not adequately account for national variation in the *goals* of state partnerships. If the Cambodian health system is a puzzle, with NGO services filling in certain missing pieces, the pieces funded by Japan and the U.S. are dissimilar shapes. Researchers have illustrated how, in the past, different nations' cultural interpretations of the colonized needs and the colonizers own relationship to them impacted colonial state policy (Steinmetz 2008; Wilson 2011). In a similar fashion, the goals of state partnership—*what*

promoting state capacity in public health means—and subsequent state partnership activities, vary by national origin of the INGO.

As I discussed in detail in Chapters Two and Three, the U.S. and Japan apply different sets of schemas to evaluate development problems and imagine solutions, due to their distinct economic, political, and cultural histories (Escobar 1995; Lamont 2000). I call these sets of schemas national development imaginaries. The U.S. development imaginary, broadly consistent with what might be described as a neoliberal model, understands national development as a process that unfolds via global economic integration, and centers on the market, with the state playing a supportive role. In contrast, the developmental state holds a preeminent place in Japan's imaginary, with government institutions and officials occupying center stage. In bilateral agencies and headquarter organizations, practitioners draw from available schemas to understand the needs of developing countries and construct possible solutions. Thus, imaginaries shape the types of state partnership activities international organizations in Japan and the U.S. define as useful and fund.

In the previous chapter, I described how development imaginaries and the concrete programs and plans that proceed from them are articulated in the Cambodian context. Articulation refers to the intersection of development imaginaries and their manifestation in INGO programming and practices within the context of Cambodia and the agency of Khmer practitioners. Development is neither a singular nor a unidirectional force. Instead, as I show, the programs and practices constructed within distinctive national development imaginaries are articulated in recipient contexts, providing distinctive opportunities and constraints on local practitioners and stakeholders. As this chapter will show, an INGO's goals can be more or less compatible with recipient contexts, and goal alignment or resonance with a recipient nation impacts the articulation process and partnership outcomes.

Below, I first illustrate how the development imaginaries in which practitioners at Health Services Asia (HSA), Global Family Aid (GFA), and by extension, GFA's implementing partner, the Cambodian Development Society (CDS) are embedded produce dissimilar visions of the role of the state. Then I examine the articulation of these imaginaries in terms of who, what, and how. First, INGOs make dissimilar choices about *who* (which state organizations) to partner with. Second, INGOs differ in *what* they do (which types of activities they pursue in cooperation with state partners). Third, INGOs differ in *how* they go about building and nurturing relationships

with state officials. After analyzing the consequences of each INGOs' vision of the Cambodian state's role in healthcare, I examine the responses of Cambodian officials to each model.

Who to cooperate with?: Differences in state partner selection

The difference in HSA and GFA's relationship with the state begins with the different types of state organizations they select as partners. However, before analyzing which state agency each INGO selects as a partner, I will briefly review the organization of the Cambodian health system. Despite the increasing effectiveness of the National Center for Maternal and Child Health discussed in Chapter Four, the Cambodian government still faces challenges in improving maternal and newborn health outcomes. Many public health workers, particularly at the non-national level, are poorly paid and lack capacity. Service implementation also continues to be limited in rural and remote areas.

As detailed in Chapter Four, the Ministry of Health (MOH) and its sub-agencies, like the Cambodian Center for Health Communication (CCHC) or the National Center for Maternal and Child Health, which are responsible for specific health topics, operate at the national level. However, the implementation of health services throughout the country is the responsibility of local-level agencies. There are Provincial Health Departments (each with their own maternal and child health unit) and Provincial Referral Hospitals for each of Cambodia's twenty-five provinces. Next, there is one District Health Department for each of Cambodia's 165 districts. Each district also has at least one, and often more, public health centers, depending on population and geographic size. Health center staff provide basic health services, including childbirth and maternal care, referring patients to provincial hospitals in emergencies. Additionally, most district towns have a number of private clinics, which charge for service and are largely unregulated by the state.

Next, local governance is further decentralized, with each of Cambodia's approximately 1,650 communes governed by a commune chief. Commune chiefs run commune councils of anywhere between four and eleven elected council members, depending on the commune size. Commune councils plan and budget for their commune area, including health education, reporting directly to the district. Finally, at the most local level of government, Cambodia is broken into approximately 13,400 villages, each with a chief. In theory, district health department officials provide financial support to and coordinate with health center staff to

manage village health leaders in each village, who are selected by the village chief to provide health education to the village.

With such a complex array of state institutions and actors, no NGO has time to cooperate in a meaningful way with all levels of the Cambodian state. While NGOs will often interact with more than one state agency, staff typically focus the majority of their energy on only one or two state partner organizations. There are numerous possible configurations of state partnership in the Cambodian public health sector. The state organization that HSA and GFA select as their main partner speaks to INGO understandings of the role the Cambodian state should play in healthcare, reflecting the donor imaginary of each nation. It also shapes how the state will respond to the partnership.

HSA and Partner Selection

HSA's provincial office is in a small district town in Stung Treng, one of Cambodia's more impoverished and remote provinces. Stung Treng is five to six hours by car north of Phnom Penh and state presence is quite limited there. The town is about an hour away from the provincial capital with a population of no more than two hundred. Power outages are frequent and only some of the houses in town have running water. Typically, you can see party offices and signs across the Cambodian countryside, but here even that is limited to a small rundown Cambodian People's Party office and a single sign when you enter the town. There is one small primary and secondary school in the town, and locals tell me the nearest high school is over 20 kilometers away. There is also one small district health center located in the town.

When asked how HSA selected this site for its provincial office, Junko draws a map of the complex organization of the Cambodian health system. She explains Cambodia's "Health Strategic Plan," which JICA played an important role in writing. According to the Plan, the provincial and district levels are considered the main implementers of the Ministry of Health's (MOH) policies, not unlike Japan's prefectures that are the main implementers in Japan's healthcare system. HSA's goal is to support Stung Treng's provincial and district level officials in effectively implementing public health services for the population, specifically maternal and child health services, as outlined in the MOH's plan. The long-term vision is that after successful implementation of maternal health services in Stung Treng, HSA will support provincial officials in documenting their improved maternal and child health outcomes. Then, alongside provincial government partners, HSA staff will promote Stung Treng as a successful model for effective

implementation at the national level. In short, for HSA, partnership comes with the assumption that the provincial health department will act as the implementing partner, meaning that the Japanese aid chain reaches beneficiaries through partnership with state officials.

Stung Treng is a province with some of the worst indicators for maternal nutrition, nutrition for children under two, and poverty. The clear need in the province for improved health services makes it appealing to HSA's donors. Before the project began, Junko spent a substantial amount of time making connections with state officials in the province, with the aid of her Khmer program managers. She traveled to Stung Treng to build relationships with the provincial health department officials who then recommended specific districts where HSA might focus its efforts. Then, she visited recommended districts to see which officials she thought had the highest level of commitment to policy implementation. In the end, HSA's main partners became district and provincial health officials in a province where health policy implementation has been particularly uneven.

Most NGOs are not willing to open main offices in remote provincial locations, as middle-class NGO staff prefer to live in Phnom Penh, provinces closer to Cambodia's two major cities, or, at the very least, provincial capital cities. Yet, as described in Chapter Three, practitioners in Tokyo often interpret 'kusanone' or 'grassroots' work as requiring close cooperation with local level government officials and HSA's headquarters promotes close partnership with local officials. Consequently, although HSA does maintain a small office in Phnom Penh, to align with these goals, HSA selects a provincial government agency to be its main partner and staff spend the majority of their time in Stung Treng to be near the relevant provincial and district officials (many other Japanese INGOs in Cambodia do the same).

GFA and Partner Selection

In contrast, GFA partners with a national-level public health sub-agency, the Cambodia Center for Health Communication (CCHC). GFA's goal is to support CCHC in creating a coordination system or clearinghouse to provide information to nonprofit, private, and public health organizations working in health education. How did GFA decide to partner with the Cambodian Center for Health Communication (CCHC)? As discussed in Chapter Two and Three, compared to JICA, USAID is more directive in the large health projects sub-granted to INGOs. In the donor request for applications, CCHC was identified by USAID as a strong candidate for coordinating health behavior change activities. The CCHC is not a sub-unit with a

large amount of political influence within the government, but it does have a history of working with international donors. According to GFA's director, Ranny, the partnership is due to one these historic relationships. GFA's health project works to revitalize a previous World Health Organization program from 2005 that supported CCHC as a health education coordinator.

However, CCHC's history with international donors has specific consequences for the partnership. One day, I attend a workshop with GFA and CCHC staff. Its purpose is to help CCHC "create a marketing campaign" to "brand themselves" as the health behavior change experts and coordinators in the Cambodian health sector. The facilitator inquires why CCHC was originally created. An older CCHC staff member reflects on the health unit's origins. The sub-unit was set up in 1994 by the Ministry of Health (MOH). At that time, CCHC was created for disease prevention projects, a topic that international donors and NGOs were pushing in Cambodia and that multilateral donors were providing funding directly to the CCHC to implement. While not said at the meeting, it must also be noted that the CCHC originated during the period when the CPP created several government units in order to increase its client-patron networks, rewarding the politically loyal with government positions (Un 2005).

As its origins suggest, CCHC is highly donor-dependent and its role, to promote health communication in Cambodia, is rather ambiguous. Over the years, CCHC has worked on numerous media campaigns such as tuberculosis, HIV/AIDs prevention, smoking cessation, hygiene, etc., largely funded by international donors, such as the UN and World Health Organization. At the marketing workshop described above, CCHC staff admit their organization's mission has shifted with donor trends, making it difficult for them to clearly define, much less create, a marketing campaign around CCHC's unique, signature role.

In summary, the CCHC was deemed the best candidate for this coordination role by USAID due to its history working with international donors on coordination and perhaps, because it is a more 'civil society-like' government unit. A large percentage of its funding comes from international donors, it plays little to no role in health policy construction, and it competes with other health sub-units, such as National Center for Maternal and Child Health and the National Center for Tuberculosis, for funding from international donors. It is possible this situation may allow GFA, and USAID as a donor, to have more influence over the CCHC's activities.

However, as you will recall from previous chapters, health programs with funding from the U.S. travel through longer and more complex aid chains. Thus, U.S. cooperation takes place at two levels: the national level in GFA's country office and at the local level through its local NGO sub-grantees who implement health programs. GFA funds local NGOs, like the Cambodian Development Society (CDS), to directly implement maternal health and family planning education as described in chapter five. CDS illustrates two things about GFA's coordinator vision. First, GFA's funding to nonprofit implementing partners like CDS furtherer demonstrates its assumption that the government will be one among many health service implementers. The U.S. aid chain presumes a hybrid healthcare system with services provided through private, public, and non-profit organizations, not unlike the U.S.'s hybrid health care sector.

Second, CDS's relationship with the state reinforces the state's coordinator role. While its main focus is implementing health education programming, CDS also cooperates with state officials. As CDS's director explains, to implement its projects the organization 'carefully cooperates' with local state officials, including district health centers, commune councils, and village chiefs, informing them of activities, asking for their advice on specific needs in the area, and attending NGO meetings coordinated by local government offices. In doing so, CDS supports GFA's 'state as coordinator model' by asking commune officials for input about programming and where the implementation of CDS's services are most needed. This is the kind of role GFA imagines CCHC enacting on a national scale. In pursuit of this goal, GFA not only actively promotes the idea of CCHC as a coordinating institution; it also supports the communication between the CCHC and one of GFA's own local NGO partners, CDS, as a model of how such coordination can function on a national scale.

Unpacking the multiple organizational levels of the Cambodian state, we can see that the Japanese and U.S.-based aid chains presented here select distinct state organizations as partners due to their divergent goals for the role the state should play in healthcare. In the next section, I will describe the results of the different roles promoted by each aid chain: 'implementer' in the case of the Japanese chain and 'coordinator' for the U.S.-based one, detailing the different activities employed to promote each role.

What they do: Partnership Activities

HSA's Activities

At a staff meeting, Junko quizzes her staff members on Cambodia's new maternal child health guidelines. These guidelines were created by the Ministry of Health (MOH) with the support of the World Health Organization, the UN, and JICA. She asks, 'How many times should a pregnant woman visit the health center?' 'How long does the policy say a woman should breastfeed exclusively?' A few seasoned staff members answer her questions, while newer employees look confused, unaware they were going to be quizzed on the specifics of government policy recommendations. She continues, telling new employees they were given the policies to read when they came in, and this is how they do things here. 'We know the government policies better than the government staff!'

At HSA, staff are knowledgeable about the Ministry of Health's policies, particularly those in the strategic plan that outline maternal child nutrition and health services. Unlike GFA, where project goals include support to grassroots organizations, private clinics, and the state, HSA has one central mission: to aid its state partners to implement the MOH policies at multiple sub-national levels. Specifically, the goals detailed in HSA's program documents state that HSA will improve the health of mothers and children in Stung Treng by improving provincial and district officials' managerial and training skills, improve health education provided by commune and village level officials, and increase state capacity to monitor the nutrition and health condition of mothers and children. All project activities involve improving the capacity of state employees in order to advance the health of women and children in HSA's target areas. HSA staff do not implement any health services directly to beneficiaries.

In part, accomplishing the goal of aiding state officials in implementing health services takes the form of the 'training of trainers' model described in the previous chapter. This means training higher-level government staff to provide health education training to sub-national officials in the ranks below them. The 'training of trainers' model, in which for instance, a doctor might train nurses, and then the nurses would then go to train community volunteers, is not new in development practice. However, the way HSA deploys this model displays its centralized emphasis on state partnership.

For comparison, the German bilateral agency, GIZ, might be a considered a bilateral development agency that closely resembles JICA, since it also implements the majority of its programming in close cooperation with the Cambodian state. GIZ also funds and implements maternal and child health projects in Cambodia. To do so, GIZ also employed the training of trainers model, working directly with provincial hospital doctors to train midwives on emergency obstetric care. Additionally, though, GIZ engages local NGOs to provide health trainings directly to local communities in order to, as one GIZ official reports, "build Cambodian civil society." In contrast, HSA provides health trainings solely to government health staff. As the programmatic content of these activities has been discussed in the previous chapter, here I will only discuss HSA's interactions with state officials.

HSA's main state partner is the Stung Treng provincial health department. HSA staff work closely with the head of the provincial maternal child health department, Dr. Kim. For the first training of trainers session, we meet with Dr. Kim to plan how he will enhance the capacity of district level staff. Upper-level HSA staff, Boran, Samnang, and Sovann, respectfully confer with Dr. Kim about the best way to conduct the workshop and which topics are most important to cover. HSA program assistants prepare materials such as whiteboards, markers, and flip charts with photos of the different food groups.

The next day the second level of training takes place. In the provincial hospital meeting room, two district health officials from HSA's partner districts arrive. Sovann, Samnang, Boran, and Dr. Kim support district staff in preparing posters and presentations, and discussing maternal and child health information. Finally, in the afternoon, Dr. Kim and the district health officials practice presenting detailed trainings on different health topics, such as maternal nutrition, breastfeeding, and how often pregnant women and new mothers should visit the health clinic. HSA staff and Dr. Kim provide feedback to the district health officials.

The next week, at HSA's office, Dr. Kim and the two district officials make these presentations at the workshop provided for health center midwives and nurses from health centers in different communes, and a few female officials from different Commune Councils for Women and Children (CCWC)[25]. After this training, HSA then supports the fourth level of trainings, in which CCWC leaders and health center workers train village health volunteers on

[25] As discussed in Chapter Four, CCWC officials are members of the commune committee that are charged with advocating for the needs of women and children.

these topics in their own communes. For the final training, village health volunteers and health center workers implement community health trainings in villages. Here, HSA staff attend to monitor that these trainings take place, run smoothly, and help with data collection on the number of pregnant women and young children in the villages within their service area.

During a village health training, as HSA program assistants help health center staff cajole babies onto scales to monitor their weight, I watch as Samnang interacts with the village health volunteer who is about to give a breastfeeding and nutrition training. She asks him, 'six months only breastfeeding, is that correct?' Samnang answers affirmatively, briefly reviewing the information in the flipbook with her before she begins her short presentation. Catching Samnang after the event, I inquire, why he doesn't give the training himself as other NGOs often do. He states, 'this is a government activity -- they need to do it,' going on to ask me rhetorically, if he did it for them, who will do it when HSA is gone? "HSA helps the government to do its job."

Supporting a strong public health system is a clear manifestation of the Japanese development imaginary. HSA headquarters staff argue they are working under the UN's directive to promote universal healthcare[26] but they also compare HSA's work in the provinces to the development of maternal and child health services in Japan's prefectures after WWII. The commitment to community health workers mirrors the development process of Japan's rapid improvement of maternal child health with the help of community nurses and midwives after WWII as described in Chapters Two and Three (JICA 2005; Knoema 2018). As we can see, HSA's activities in Cambodia are profoundly impacted by this. HSA staff are deeply committed to the idea that the state should be the central implementer of health activities.

GFA's Activities

As explained in Chapter Two, U.S.-based INGOs work in more complex aid chains, meaning that beyond USAID, GFA received support from multiple international donors with diverse goals, like the International Planned Parenthood Federation, for which it implements other projects. Working under the U.S. imaginary, which simultaneously promotes civil society, public sector support, and market sustainability, GFA manages numerous activities and donor agendas. These agendas are sometimes in conflict, such as civil society promotion activities that cause strained relations with government officials, and thus hamper efforts to cooperate with

[26] https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/universal-health-coverage-for-sustainable-development---issue-br.html

state officials. Thus, unlike HSA, where all donor funding was channeled towards a single project, GFA is a large organization and staff need to balance multiple projects.

As explained in Chapter One, for the purposes of comparison with HSA's JICA-funded health project, this research focuses on GFA's largest project, its USAID-funded health project to promote health behavior change. Yet even when narrowing my discussion of GFA to a single project, the organization's larger size and complexity compared to HSA makes the comparison inexact. The budget for GFA's health behavior change project is substantially larger than HSA's project (10 million vs. 1 million USD) and the single project has multiple goals that involve diverse partnerships. GFA sub-grants to and monitors local NGOs in implementing programs in five distinct health sectors (Maternal and Child Health, Family Planning, Child Nutrition, Water, Sanitation, and Hygiene (WASH), and Tuberculosis), support the public health system in its coordination role, and enhance the quality of private clinics. Managing this large number of activities, GFA's program staff do not have the same amount of time to devout to building strong relationships with government officials as HSA staff. In contrast to HSA, GFA also faces tension due to the strained geopolitical relationship between Cambodia and the United States, and the Cambodian government's mistrust of USAID and the U.S. government more broadly.

It is in this context that GFA's state cooperation activities take place. On my first day at GFA, I was given not government policies to read, but a stack of glossy USAID/GFA branded documents about the project. One of GFA's main objectives, alongside implementing health behavior change programs in its target areas and supporting private clinics, is to 'strengthen the public sector.' It does so by cooperating with the CCHC to improve its expertise in health behavior change and ideally, to create a coordination system for public, NGO, and private organizations implementing health behavior change projects in Cambodia.

Encouraging CCHC staff to enact a coordination role occurs via numerous meetings and workshops. These workshops are to take place for the first two years of the project to upgrade the technical skills of CCHC, after which point GFA will take on more of a monitoring role. The topics workshops address include marketing CCHC as a health behavior change expert and coordination agency, CCHC organizational analysis and financial advocacy, health behavior change handbook design, and health behavior change database management and usage. As described in Chapter Two, U.S. INGOs contract out numerous activities to private actors and other NGOs. Thus, international experts are often hired to conduct particular meetings. In the

case of the project I studied, this included meetings organized by GFA staff and designed to try to sell CCHC officials on why they should embrace the coordinator role.

One such marketing workshop I attended was facilitated by a private firm that GFA had partnered with for its expertise in branding. An energetic German woman named Brigettee was flown in to facilitate the event. Consistent with the U.S. emphasis on 'best practice technologies,' for efficient and effective programming Brigettee uses up-to-date tools of 'human centered design'[27] in the meeting, employing numerous visual tools to stimulate CCHC to 'solve their problem.' To begin the workshop, she provides the CCHC officials in attendance with data she and her staff collected about the current lack of knowledge on CCHC's role in provincial health offices and other sub-units. Then, she informs them that she can help them position their organization as 'the expert in Cambodian health behavior change.'

Brigettee asks CCHC staff to estimate how much time per month the CCHC can spend on coordination. By this point, the CCHC's director, who has been perusing the data that Brigettee offered, seems annoyed. First, he asks her questions about the data, who her staff interviewed, where they did so, and if she is suggesting that CCHC's current work is not important. Then, he addresses the topic of CCHC taking on the new coordination role supported by GFA and described by the consultant. He asserts energetically that 'we have our roles in the ministry to worry about, we have no free time to approve NGOs, private clinics, or other sub-units' work; my staff needs to be paid more if you are going to bring more work.' He goes on to ask Brigette, why do you 'bring more work but not more budget?' Unlike JICA which provides per diems, USAID has strict rules against paying government officials and CCHC staff do not receive per diem for attending GFA's workshops, much less payment for coordination activities.

Brigette pivots, enthusiastically stating that the workshop should move to a discussion of how CCHC can set itself up to get paid for its coordinator role. The CCHC deputy director cuts her off, explaining that they had this problem with the previous World Health Organization project; the Ministry of Health (MoH) does not condone taking money for coordinating projects. He says the World Health Organization was informed of this during the previous coordination activities and went to MOH about the issue, but nothing changed. He starts talking about possible workarounds, like taking per diem from NGOs to support CCHC's coordinating work, at which point Brigettee looks to Ranny for help.

[27] https://www.designkit.org/human-centered-design

Ranny jumps into the conversation, speaking initially in the workshop language of English and then switching to Khmer. She is respectful, calculated, and convincing with her words. She explains she is just an NGO director, and one NGO does not have the power to coordinate all the health behavior change actors. She is aware the CCHC was not created to coordinate NGOs, but there is a real need for it; if the entire country had consistent and coordinated health behavior change programming, the implementation of health services by non-government actors would be far more effective. In her opinion, MOH has the money to cover this activity, but it needs to see its usefulness first. If the CCHC shows MOH how effective it is in coordination, perhaps it will be able to carve out a permanent funding niche for itself in the government budget. She finishes speaking by noting that, of course, this is the CCHC's decision, as they are the government officials. Despite Ranny's words, CCHC's deputy director does not concede, continuing to insist that MOH will never fund such activities. Such disagreements over the feasibility of the coordination role were not uncommon. GFA continued to promote the usefulness of health behavior change coordination, but it remained difficult to get buy-in from CCHC staff.

At another workshop, CCHC is asked to identify its organizational goals for the future. One that attendees identify is financial sustainability. The facilitator, an INGO practitioner from Eastern Europe this time, writes this goal on a poster board and provides possible sub-headings like budget advocacy, resource mobilization strategy, and marketing strategy. Next, CCHC staff are broken into small groups to discuss the different goals that have been named, which are written on posters in different areas of the conference room. When it comes time for the financial sustainability group to present, it does not go the way GFA staff hoped. To the CCHC staff presenting the results of their deliberations, budget advocacy has a different meaning. While they were tasked with discussing how to secure funds from the MOH, they cross out MOH and write "advocate for funding from donors like USAID, UNICEF, EU, UN, and UNFPA."

Outside of large workshops, GFA staff also have periodic smaller meetings with CCHC leaders. There, GFA tries to get CCHC's 'input' or 'approval' on the implementation of health behavior change education aspects of the project, something USAID highly encourages. CCHC and GFA staff discuss program design, target beneficiaries, effective health behavior change messages and CCHC's needs in numerous meetings. However, these meetings are not always regarded as useful. After returning from a meeting on health behavior change messages, Panh

informs me it is difficult to get CCHC to make decisions; they don't provide useful input, and it is increasingly challenging to get attendance from higher level staff. Moreover, as part of the collaboration agreement between GFA and CCHC, a few members of GFA's program staff also go to the CCHC to 'work together' a few days each week. However, neither party seems completely clear on what they should be doing together, and GFA staff report that they are largely left alone at the CCHC office.

In short, GFA's state partnership activities include multiple expert workshops and meetings encouraging CCHC to cultivate its capacity as the health behavior change coordinator in Cambodia. GFA's promotion of CCHC as a coordinator of state, private, and non-profit actors assumes a hybrid healthcare system as the ideal model, and this could indeed be a useful role for CCHC to play. Cambodia has an enormous number of international and local NGOs implementing varied health behavior change projects, and numerous unmonitored private clinics in most provinces. If one government institution could monitor all of these activities, standardize health education and services, and let new NGO projects know where programming is needed, it would make health behavior change activities more effective. Nevertheless, this is a very different model of state capacity than pursued at HSA. Furthermore, as GFA subgrants to the Cambodian Development Society (CDS) for its USAID project, I will examine how the goals of GFA's state partnership are implemented at CDS.

Cambodian Development Society's Activities

The Cambodian Development Society (CDS) plays the role of a non-profit implementer in the U.S. funded aid chain. Similar to GFA, CDS faces the constraints of conflicting donor demands. The director, Rith describes his organization's main goal as helping women, children, and 'vulnerable people' in their province. Staff implement diverse program activities with funding from three different INGOs, a Scandinavian foundation, and a university in the United States.

Implementing GFA's project, CDS is careful to inform local state officials of its activities and ask for their input on where implementation is most needed. For the health team, state interaction amounts to careful conversations about cooperation and informing government officials of their work. I observe this firsthand when I traveled with the manager of CDS's health team, Reasmey to one of CDS's target communes. We meet her health team officers based there. Before going to conduct village health trainings, we go to the commune office to talk with the

deputy commune chief. After introducing herself, Reasmey carefully explains CDS, what the project is about, how it will help women in the area (by preventing maternal death, a neutral and appealing goal), and asks for their 'input.' Formally, the deputy chief tells her he believes decreasing maternal death is a worthy goal and describes a few villages that might need her attention. After gaining the 'support' of the commune leaders, we head out, and she and her team members travel to multiple villages, conducting community trainings for women. When I ask Reasmey about the purpose of the preliminary meeting with the deputy chief, she informs me that it is for 'government cooperation,' we just need them to 'know us and approve our plan.'

According to Reasmey, the biggest hurdle in securing government cooperation is for community events, in which she needs to gather twenty to thirty community members for a large family planning and maternal health training. In this case, she must take special precautions to get permissions from commune and village leaders so her event is not misconstrued as mobilization against the CPP. To get permissions, she will meet with the commune chief and village chiefs and inform them that the purpose of the event is to promote women's health. Then, the village chiefs will get the female village health volunteers to help Reasmey and her health team gather attendees. However, village health volunteers and government officials play little to no role in the training, outside of providing permissions. In the community event I attended, Reasmey and her health team presented the health education to twenty women. After the health training, CDS's monitoring and evaluation manager, Leap, gets up to speak. He informs the women about CDS and their activities in the province. He goes on to say the government should be providing this health information but they lack the capacity to do so. CDS is here to fill in for the services the government cannot provide.

Supporting the GFA's goals, CDS allows the state to act as a coordinator of its activities, at least in a limited way. In the next section, I explore the nature of the relationships between NGO staff and state officials.

How to do it?: Relationship Building

HSA's Relationship

In addition to trainings described above, HSA spends a substantial time attending government meetings. Most INGOs devote significant time and money to meetings and workshops, a phenomenon referred to as the 'technology of talk' in which NGOs, with vague

goals and without a concrete plan to implement, often turn to talk (Watkins, Swidler, and Hannan 2012). However, unlike U.S. INGOs, HSA does not work with any private clinics and spends minimal time networking with other international and local NGOs. Other NGOs are only encountered at larger provincial and district health planning meetings. In my time with HSA, I saw staff meet with another NGO working in Stung Treng only once, at the provincial health department's behest.

In contrast to the short shrift given to relationships with NGOs, HSA staff spend an inordinate amount of time attending to government relationships, as the example at the beginning of this chapter shows. While most NGOs attend government meetings, they are typically strategic about which ones they attend. In contrast, HSA staff attend government meetings about two to three times per week. To get to know all of the officials in their area, HSA upper-level staff members attend health planning meetings for the province and the three districts in which they work. Each of the districts has between six and twelve communes, and HSA staff also often attend commune planning meetings. Additionally, they support health center planning meetings for the four health centers in their districts and tri-annual village health volunteer meetings at each of these health centers.

Sovann tells me about a recent commune planning meeting, where he briefed commune leaders about their budgets, and how to access the funds available to them at the national bank. As he explained, the commune treasurers aren't always well-versed in banking matters, so he helps them understand how to access the funds. Then, he gently informs them about HSA's data on maternal and child health to promote allocation of the commune budget towards the community health programs HSA currently funds. However, he "doesn't push this too hard" as it is also his job to get to know them, and listen to their ideas. Sovann tells me, 'if we give them too many ideas, next time, they might just listen to me and not have ideas of their own.'

HSA's staff maintains an elaborate knowledge of state policies, take a backseat role in implementation, and gently promotes policy implementation at government meetings. HSA's assumption that government officials will implement, while NGO staff take a supporting role, is in stark contrast to U.S.-based NGOs that generally implement programs directly through local NGO partners. Through these activities, HSA displays a firm commitment to the 'state as implementer' model, assuming that in an ideal future, the state will successfully provide health services without the support of organizations like HSA.

HSA staff maintain strong friendships with numerous Cambodian officials. When HSA staff find government officials with the right power networks and willingness to cooperate, staff build meaningful and personal connections with them. For example, program managers meet with Dr. Kim often, spend informal personal time with him and his family, offer him opportunities to travel to Phnom Penh for workshops, and at the time of my fieldwork, HSA is planning to provide Dr. Kim with the opportunity to travel to Tokyo. At the end of my stay with HSA, the staff held a party for me. In attendance at this event were not just HSA staff members, but also two district health doctors, a district governor, and Dr. Kim. Male HSA program managers and provincial and district officials tell stories, sing, and try to convince me to taste homemade herbal liquor.

Strong relationships with state partners served HSA well in numerous ways. First, in interactions with government staff, NGO workers must worry about how to 'save face' as it is frowned upon to give direct advice or criticism to people who are equal or superior to you in the social hierarchy, like government officials. Friendship allowed HSA program managers to engage in informal conversations about health education, though managers were careful to defer to provincial doctors' authority. For instance, Samnang always asks Dr. Kim questions, deferring to his expertise on topics like what would improve the diversity of food groups eaten by pregnant women in their province. However, cordial conversations allowed HSA staff to politely float new ideas to provincial and district officials. Overall, in the delicate tango around government partnership and power hierarchies, HSA staff are smoother dance partners than GFA practitioners.

This relationship is certainly influenced by the friendly geopolitical relations between Cambodia and Japan, but it is also due to HSA staff's patient and dogged engagement with local power networks and their careful investment in choosing the right state officials to cultivate as friends. As discussed in the previous chapter, HSA's Khmer program managers are not passive recipients of Japanese staffs' program ideals. This articulation takes place, in large part, because HSA staff pursued positive relationships with state officials, not just to further HSA's work, but also because doing so aligns with their strategic interests. Program managers all have hopes of moving into public health jobs later in their career. The personal ambitions of managers will be discussed more fully in the next chapter.

In summary, the goal of HSA's partnership is to support the state in becoming a capable implementer of maternal and child health services. HSA's understands a strong Cambodian state as both the means and the end of development insofar as its desired outcome is a strong government-run public health system. This vision of the state as implementer means HSA supports state actors to implement health services, and this requires building close relationships with state partners in order gain their trust and secure their engagement.

GFA's Relationship

As we saw above, managing numerous activities, GFA program staff lack the time and energy to create the strong government relationships that HSA staff enjoy with Cambodian officials. After a staff meeting one day, the chief of party, Dr. Belinda laments the difficulty of fulfilling the project requirements. GFA needs to cooperate with the state, help them to fulfill the cooperation role but GFA also has to work with private clinic partners and oversee local NGOs' implementation of the project activities. She laments, "how can we do it all?"

In contrast to HSA's friendships, GFA's state cooperation is more of a *performative partnership*. GFA staff see state cooperation as another donor-requirement box to check off by attending meetings and conducting the workshops outlined in the workplan. There is a lack of commitment on the part of GFA staff and sometimes open resistance to the partnership. Because of the many goals and numerous activities staff must balance and the organizational culture in which they are embedded, GFA staff spend less time building government relationships. Staff members are deeply embedded in social networks with other NGOs and private clinics and they are less interested in building relationships with state officials, shaping how GFA's state partnership articulates.

In contrast to HSA where the vision of success is effective public health implementation, for GFA, the outcome of a successful partnership that enhances state capacity is the CCHC enacting a new coordination role. Following the U.S. development imaginary in which the state supports the market, GFA believes CCHC should regulate health education services provided by private and nonprofit healthcare actors in addition to public health centers. It implements capacity building workshops to support CCHC in developing coordination skills. However, this vision is not easy to implement. In part, the articulation in which GFA's partnership goals are so far unsuccessful in the Cambodian context is due to the fact that GFA staff lack both time for and interest in relationship building with state officials. But, as we will see below, it is also difficult

due to distrust of Western donors and the lack of Cambodian state engagement with private health clinics. However, before we can discuss the Cambodian state's engagement, I will detail the relationship of CDS staff with Cambodian officials.

CDS's Relationship

Following GFA, CDS staff have an ambiguous relationship with state officials. CDS lacks the direct support of the large bilateral donors that fund GFA and HSA, which provides it with considerably less influence vis-à-vis the Cambodian state and fewer resources to entice Cambodian officials. It also faces competing donor demands that can create tensions with state officials. Specifically, one of CDS's projects, funded by a Scandinavian donor that wants to educate rural communities on children's rights and mobilizes them to voice concerns to education officials, a project that does not meet the approval of state officials.

While I will mainly discuss cooperation between CDS and state officials as it relates to CDS's role in implementing GFA's project, it must be noted that CDS' diverse donor goals mean the organization must carefully negotiate its relationship with the Cambodian state, which restricts NGOs it views as too radical. CDS's director, Rith describes how he deals with projects that require state cooperation and confrontation at the same time. Rith, who founded CDS in the early 2000s, says 'it is not so easy but not so bad.' He explains he acts as a 'careful mediator.' 'I want the government to think we are there to help them, but also I work with the grassroots people to improve the community voice. It is CDS's job to help the poor people, so we work between the government and the people. But, we must be careful; they [government officials] cannot think we are raising the people against them or they will blacklist us." He goes on to explain that he was previously a monk so it often helps him to ground his desire to help the poor in Buddhism, allowing him to present his work as apolitical.

Thus, as described above, in its limited state interactions, CDS allows the state to act as coordinator, directing where it implements activities, for example, which allows CDS to keep donors and state officials alike happy. In this way, CDS does allow the Cambodian state to 'coordinate' its activities. Supporting CDS and other local NGOs to implement health education illustrates GFA's support for Cambodia's hybrid healthcare service model. However, the health team's cooperation with the Cambodian state is surface-level and limited. It engages with private clinics in GFA's networks and refers beneficiaries there far more often.

Having detailed the differences in the U.S. and Japanese approaches to state partnerships, I turn finally to a discussion of the distinct responses of state officials to each model and explain how these responses affect the outcomes of each partnership.

The State Acts Back: Cambodian State Partners' Responses

A high-ranking Ministry of Health official speaks at a national health workshop. In a lengthy speech given to health officials and employees of international organizations, the official advocates that Cambodian government officials must be allowed to "be strong" and "take the lead." She goes on to explain that while international donors helped Cambodia immensely after the Khmer Rouge, the Ministry of Health has grown in its capacity, and no longer needs to be "led around" by the agendas of donors. "We must lead in health implementation now!" As her speech illustrates, Ministry of Health officials are not passive recipients. Rather, state officials actively negotiate NGO partnerships and this process is incredibly influential on how program goals articulate in the Cambodian context.

Having experienced years of international development programming, developing-country states are finding new and innovative ways to negotiate partnerships with NGOs (Brass 2016). INGO aid often comes with the backing of powerful bilateral and multilateral agencies and, sometimes, developing states are dependent on INGO services to fill in welfare gaps. Nevertheless, developing states are active participants in partnerships with INGOs. Chorev refers to this phenomenon in which developing state negotiate incoming aid programs as "bargaining in the shadow of power" (2019: 3)[28]. For instance, developing states increasingly constrain INGOs by making laws restricting INGO and local NGO activities. Such laws can create an unreceptive environment for partnership (Bromley, Schofer, and Longhofer 2019). Yet, developing states may also cultivate partnerships by funding local or international NGOs directly, partnering in social service provision, or participating in technical skills building workshops (Brass 2016; Kudva 2005). The outcome of INGO-state partnerships is deeply contingent on local conditions, particularly how an INGO's goals resonate with the interests and needs of state partners. Below, I detail how state partners respond to GFA and HSA's partnerships.

[28] However, it must be noted, her work examines foreign aid that is provided directly by bilateral and multilateral agencies, which may hold more power vis-a-vis developing states than INGOs, even though the latter count among their donors the same bilateral and multilateral agencies.

In HSA staff's commitment to the Japanese vision of the public health system, they also prioritize the policies of the Cambodian Ministry of Health (MOH). As the above example of the high-ranking official demonstrates, the Cambodian state is currently working to upgrade its public health system. HSA follows this directive. For instance, in the beginning of the chapter, we see Junko exclaim, HSA's programs are all about "their [MOH] policy." Emphasizing the policy of the MOH provides HSA with considerable legitimacy in the eyes of state officials.

Dr. Kim reports he knows HSA programming is good for Cambodia because "their program and the MOH policy are the same." Furthermore, HSA's staff form an alliance between with state officials. As illustrated in the previous chapter, state officials and HSA staff work together to adapt maternal health education to Cambodia's needs, including discussions of traditional medicine in trainings. In another example, Junko periodically tries to get her staff to start limiting the use of per diems for government officials, since it is "the job of the government to implement the policy." Thus, she believes they should do so without per diem. On this front, Junko faces extreme push back or is simply ignored. Sovann explains that "might work in Japan" but per diems are "how things work here." In his opinion, paying officials is necessary for building successful relationships with them and a critical part of the "slow" process of convincing them to implement maternal child health services on their own.

Thus, at HSA, in many cases, officials actively participate in NGO trainings and meetings. For instance, in one workshop, Boran and Samnang spend three days discussing HSA's baseline data with Dr. Kim. They examine findings on maternal nutrition, child nutrition, sanitation, maternal health center visits, and birthing practices, while carefully respecting Dr. Kim's knowledge as a provincial health official. By the end of the workshop, Dr Kim enthusiastically practices his presentation about HSA's data as if it is the provincial government's information. He plans to make a similar presentation at the provincial and then national maternal and child health conference in the next few months. Dr. Kim thanks them for helping him. This would not happen at GFA, where data is publicly presented by GFA staff and carefully branded with USAID/GFA logos. When I ask Samnang why he will not present the data, he says, what we do is 'empower state officials to do this themselves, to implement their own policies.' This is a very different notion of the "who" and "how" of empowerment than we find in U.S. INGOs, and, one that resonates with state partners.

The active participation of state partners means HSA is able to implement the goals of the partnership, including upgrading the skills of public health staff and community trainings. However, it must be noted, despite HSA's successes, HSA is only successful in building relationships with some officials. HSA staff spend an inordinate amount of time searching for committed public health staff among many who do not wish to engage with their programs. Additionally, it is unclear whether implementation will continue once HSA is no longer at least partially supporting the health education services. Sovann expresses this concern to me: "we try to find the most committed officials… but it is not easy… and once the money is gone you don't always know what they will do." HSA staff gently advocate for officials to direct their budget towards these services but only time will tell if HSA's state as implementer model is able to create sustainable changes to state capacity. Nevertheless, HSA's understanding of the state's role in providing public health services fits with officials' vision of the need to upgrade Cambodia's public health system. Thus, many officials actively participate in HSA programs.

Contrastingly, GFA's state partnership proves more challenging. In the Cambodian context, the coordinator model envisioned by GFA is not legitimated in the policies and funding structures of the Ministry of Health. Distrust of USAID and Western INGOs is also prevalent among state officials. Furthermore, the Cambodian state has limited engagement with private clinics. State officials typically feel Ministry of Health (MOH) has its hands full trying to improve the public health system. Thus, CCHC officials resist GFA's entreaties to embrace the coordinating role.

CCHC officials also doubt that the MOH will support such a role. At a workshop, I sit with an older CCHC staff member. She has worked for the organization since the 1990s. As the meeting nears a close, she inquires when GFA and USAID will provide CCHC with the computers, server, and technical assistance outlined in the program documents. She gruffly reports GFA is asking them to come to endless workshops and meetings but she is tired of talk. She is beginning to wonder if she can trust GFA to provide the computers. She goes on to explain, the coordinator role will not work. It is just "talk" and "MOH will not provide funds to CCHC for talk." CCHC requires donor support, "that is how we do things." In the past, the majority of CCHC's funding has comes from international donors. Therefore, at least in part, CCHC seems engage in the partnership with GFA and USAID for the benefits it will receive.

Furthermore, while program staff are largely Khmer at GFA, heavy dependence on non-Khmer technical experts to facilitate workshops strains relations with CCHC further. Experts lack knowledge of the Cambodian context, including the language, and they did not have relationships with CCHC officials. It is clear to GFA staff that the role of coordinator does not yet resonate with the CCHC but they are beholden to the priorities of USAID. At a staff meeting, the deputy director, Erin notes CCHC's lack of commitment to the coordination role. Ranny agrees saying, 'we need to change strategy.' She suggests championing the role on a higher level to the CCHC director herself. In Ranny's view, CCHC 'dreams small and thinks only of day-to-day work' and GFA needs to support them to see the 'higher vision.' The CCHC could be strong and advocate MOH to support health coordination as USAID envisions. But, the lack of resonance of the model with officials as well as GFA staff's performative partnership makes it very difficult to convince CCHC staff to enact the coordinator role.

Thus, CCHC sustainably enacting a coordination role would require a change in its organizational culture and a transformation in MOH funding structures. Additionally, CDS, GFA's partnership organization, also displays the limits of this model. CDS interactions with state officials are limited, engaging with them largely to avoid restrictions or 'blacklisting.' Thus, while GFA support to local NGOs fills gaps in state service implementation, at the time of my research, GFA's goal of creating a health behavior change coordination mechanism in partnership with CCHC remains largely unfulfilled. GFA's partnership goals cannot be implemented effectively both due to lack of time for relationship building on the part of GFA staff and limited resonance with Cambodian state officials. In summary, the outcomes of each partnership are illustrated in table 5 below.

Table 5

	INGO Partner	**State Partner**	**Outcome**
HSA	State as Implementer • Provincial Health Department Selected • Training of the trainers & state implementation • Friendly Relationships	Provincial Health Department • Legitimacy from following MOH policies • Positive geopolitical relations between Japan and Cambodia • Cooperation due to positive relationships	Cooperation with implementer model
GFA	State as Coordinator • CCHC Selected • Workshops & meetings • Performative Partnership	CCHC • Lack of per diem payment • Negative geopolitical relations between the U.S. and Cambodia • Distrust in GFA staff	Rejection of coordinator model

A Cambodian State in Their Own Image

This chapter explores different understandings of the role of the developing state in Japanese and American aid chains. NGO-state partnerships supporting developing state capacity are increasingly common (Brass 2016). But, the nature and outcomes of these partnerships in developing nations varies. Often, researchers attribute this variation to differences in recipient country context. However, I argue that while developing state context is important, it is only part of the story. While HSA and GFA both engage in partnerships with public health agencies, they conceptualize what the state should do very differently. Embeddedness in each nation's development imaginary and then, how program activities articulate in local context shapes the partnerships each is able to INGO pursue. Scholarly work needs to investigate how INGOs from

different nations promote different state partnership goals in order to explain the diverse outcomes of NGO-state cooperation.

I also illustrate the differential reactions of state partners to each INGO's vision. State partners determine whether or not the goals of the partnership make sense with their needs and organizational practices. While state actors might 'bargain in the shadow of power,' whether or not they interpret each partnership as legitimate, useful, and feasible deeply impacts the outcomes of each model. In HSA's case, state actors cooperate actively with HSA's activities which are legitimated by the Cambodian Ministry of Health and undergirded by strong relationships between state and NGO staff. Yet, in GFA's case, the state distrust of GFA and lack of engagement with private health clinics mean CCHC staff resist GFA's partnership goals. Nevertheless, we can imagine that in another nation, the state might actively be working to regulate the private sector. In this context, GFA's state as coordinator model would likely be more effective than HSA's implementer model. Thus, this chapter demonstrates that even when accounting for national variation in partnerships, studies must investigate how different models articulate with the ideas and interests of local practitioners and how they resonate, or not, within developing state partners' existing practices and ambitions.

Chapter Seven
Imaginaries and Identities: Modern Development Professionals

In the previous two chapters, I investigated two ways in which the development imaginaries of the U.S. and Japan articulate in the Cambodian context: women's health programs and state partnerships. This chapter introduces a third prominent difference between Health Services Asia (HSA) and Global Family Aid (GFA): the identities of workers. As discussed in Chapter One, my conceptualization of national development imaginaries is based on insights from Edward Said's (1978) concept of imagined geography. Said's concept describes not only how those located in the Occident imagine the Orient, but how encountering the Occident's perspective on the Orient shapes the way that people in the Orient understand themselves. Relatedly, when practitioners in Cambodia encounter the dominant schemas for understanding Cambodians and their needs embedded in each national development imaginary, it impacts their self-understandings. Each development imaginary entails a vision of the type of worker that can successfully contribute to national development. I argue that encountering such visions in the INGO workplace impacts employee identities and future career ambitions.

As previous chapters illustrated, HSA and GFA enact different programs and partnerships because the national development imaginaries in which they are embedded provide different dominant schemas for analyzing the problems developing nations face, including inadequate healthcare and gender inequalities. Subsequently, HSA prioritizes the capacity of the public health system, supporting state officials in implementing maternal child health services in Cambodia. In contrast, GFA's activities support a hybrid health sector. To do so, its activities upgrade the services of private clinics, sub-grant to local health NGOs, and aid the Cambodian state in regulating private and NGO health providers. To implement these activities, HSA and GFA hire staff with different backgrounds and skill sets. I examine the backgrounds and career ambitions of Samnang and Chantrea to introduce these differences.

A program manager at HSA, Samnang hails from Phnom Penh and has a degree in nursing. After graduating from nursing school, Samnang worked in a public hospital. After a few years in as a public nurse, he came to HSA, where he has worked for the past five years. He

enjoys working at HSA because it gives him the opportunity to better understand public health issues outside of Phnom Penh and build social networks with government officials. Samnang's dream is to get a job in Phnom Penh in the Ministry of Health or the Public Health Division of the Ministry of Education. A year after the completion of my fieldwork, Samnang informs me he has successfully moved into a public health job within the Ministry of Education.

In contrast, Chantrea works at GFA as a monitoring and evaluation specialist. Chantrea has an undergraduate degree in sociology and loves research. After college, she started her career at a development research firm, which takes contracts to conduct evaluations of INGO programs. After a few years in this job, she was employed by two other INGOs to do monitoring and evaluation for a USAID project and a DFID (Britain's bilateral agency) project, for approximately three and four years respectively. Chantrea is typically only hired until the competition of each bilateral project. It's her dream is to get a permanent research position at an international development organization in Phnom Penh. She considers herself an expert in research, monitoring, and evaluation. About two months into my time at GFA, Chantrea lands her dream job and she leaves GFA to work as the permanent director of monitoring and evaluation at a UN agency in Phnom Penh.

Through the cases of Samnang and Chantrea, we begin to see the distinctive hiring practices of GFA and HSA. However, we can also see that in their broker role, Khmer practitioners do not just accept incoming practices constructed within the development imaginaries of the U.S. and Tokyo. Instead, NGO workers take up the different opportunities provided by each INGO workplace in light of their own cultural context, lives, and ambitions. I argue that, taken together, the hiring and workplace differences at HSA and GFA alongside the ways in which Khmer practitioners make sense of their work, articulates as divergent visions of a 'modern development professional' in each INGO. In this chapter, I will first examine the different workplace environments and the backgrounds of the employees HSA and GFA hire. Second, I will analyze how these differences result in varying worker identities and organizational tensions. Finally, I will discuss the future career ambitions of practitioners at HSA and GFA. However, before presenting my data, I briefly examine relevant literature on INGO work and practitioner experiences.

Scholarly Perspectives on NGO Work & Workers

Scholarship on NGOs and international development provides insights into the work lives and professional identities of NGO employees. Here, I present three prominent perspectives on the professional lives of development workers. The first literature, pushing to move the study of professions outside of the boundaries of the nation-state, examines development workers as one of many types of transnational professionals or experts (Djelic & Quack, 2010; Harrington and Seabrooke 2020). Expanding on world polity insights, studies examine transnational communities or networks engaged in the creation of global scripts or advocating for the framing of global norms within particular international settings (Henriksen and Seabrooke 2016). Transnational development actors come together in two ways. First, diverse actors come together for international meetings, such as forums on climate change or, second, disparate actors create transnational communities within large international institutions, such as the United Nations.

In transnational communities or networks, actors contend and cooperate with one another in order to construct global scripts. In these interactions, the professional identity of actors, such as health experts with particular disciplinary knowledges, shape the universe of available policies (Djelic & Quack, 2010; Mayntz, 2010). Transnational interactions can, in turn, provide members with access to new ideas and information, social connections, and a sense of belonging, influencing their professional identities (Djelic & Quack, 2010; Henriksen and Seabrooke 2016). However, transnational experts do not make global scripts in a vacuum—they have to negotiate their interests and professional identity with the contending views and priorities of other key stakeholders, such as government officials. For example, in explaining whether or not a policy will gain consensus and become dominant at the International Monetary Fund (IMF), Kentikelenis & Seabrooke (2017) document interactions between the IMF board, which represents different national political interests, and the professional development experts on the IMF's staff. This literature points to an important mechanism through which NGO practitioners are exposed to international norms and participate in the construction of global scripts and advocacy issues, but it provides little insight into the national variation seen in HSA and GFA's work environments and practitioner experiences.

The second literature takes a different perspective, investigating the constraints NGO workers face due to international norms steeped in the logic of global capitalism and donor demands for professionalization (Wallace 2004). Professionalization includes the construction of

the global development standards, the establishment of university degrees and training programs in international development, and the emergence of professional organizations and conferences (Roth 2012). Many donors and NGO employers prioritize employees with the right degrees who participate in these international communities. This has two related consequences. First, 'universal' professional norms of development largely come out of the global North. Degrees from universities in Europe, Australia, and the U.S., are privileged in the development space, and practitioners from the global North are typically treated as development 'excerpts' in NGOs in recipient contexts around the world (Roth 2012). Consequently, Western credentials are often valued over local practices in NGO workplaces, fostering unequal relations between local and foreign practitioners.

Second, because professionalization encourages the hiring of practitioners in recipient nations with specific skills, such as balancing budgets or writing grant proposals in English, local practitioners hired who have these skills may lack proximity to and connection with the "grassroots," or the local constituency that the NGO seeks to serve (Banks, Hulme, & Edwards 2015; Bernal and Grewal 2014; Markowitz and Tice 2002). Such differences between NGO workers and the populations they serve can undermine NGO agendas to challenge poverty and inequality in local contexts.

This is not to say practitioners lack agency, as they often employ creative strategies to mediate these neoliberal ideologies, professionalization, and inequalities in their work (Roychowdhury 2015). For instance, foreign NGO workers attempt to mediate salary differentials between themselves and local workers by activities like offering local staff free English lessons or paying their medical bills (Roth 2012). This perspective documents the importance of attending to how norms of professionalization impact the experiences of NGO workers. Nevertheless, this literature assumes NGO practitioners work within homogenous global neoliberal norms, something HSA's practices challenge.

The third literature investigates the experiences of NGO workers in developed and developing nations. It attends to power inequalities in NGO work environments due to professionalization, neoliberalism, and colonial histories, but it also investigates organizational practices and the meanings and motivations workers ascribe to their work more generally (Fechter 2020; Fechter and Hindman 2011; Swidler and Watkins 2017). Studies of meaning and work experience attend to questions such as the relationships between foreign and local

practitioner staff, the interactions between NGO staff and beneficiaries, how practitioners understand the moral consequences of their work, and the ways in which emotions impact NGO work (Fechter 2020; Hillhorst, Weijers, and Wessel 2012; Roth 2012; Shutt 2012; Swidler and Watkins 2017; Wright 2012). For instance, de Jong (2011) points out that many studies assume INGO workers ascribe largely altruistic meanings to their jobs. Yet, she finds that INGO practitioners in Europe are motivated by both self-interest and altruism in their work as they want to move up in their careers and help the poor at the same time.

The above three literatures analyze the work experiences of NGO staff in transnational, home country, and recipient contexts. The third literature also expands scholarly thinking by focusing on worker experiences and identities more generally, not just those produced by encounters with transnational communities or neoliberal ideology. However, across all three perspectives there is limited investigation of how differences due to donor nation of origin impact INGO work experiences. The above studies maintain an underlying assumption that the experiences of NGO staff in organizations with donors from different nations are relatively similar. I argue that we need to account for national variation in the experiences of development practitioners due to an INGO's nation of origin. To do so, I draw insights from the transnational work literature.

Studies of transnational work environments, including service work, sex work, and factory labor, illustrate the ways in which expectations placed on workers are entrenched in visions of modernity, development, and national advancement as well as a recipient nation's culture and traditions. Studies document how such expectations impact the identities and ambitions of workers (Balogun 2012; Freeman 2001; Hoang 2015; Vijayakumar 2013). For instance, Caitrin Lynch (2007) examines the experiences of workers in a multinational factory located in Sri Lanka. Female workers are pushed to embody the new ideal vision of national progress, combining incoming ideals about labor outside the home and modern styles of dress with the interaction styles of 'good village girls.' Transnational work spaces often promote particular visions of a 'modern worker' which are negotiated by workers within their own cultural contexts.

This perspective can provide insight into how donors and headquarters staffs' visions of development map onto the expectations placed on workers in INGOs. As discussed in Chapters One and Two, donors and headquarters staff are embedded in national development imaginaries,

which entail dominant interpretations of the best way for society to develop, derived from their own nation's experience. Embedded in these imaginaries, donors and headquarters staff envision the kinds of programs and stakeholders they should support, as well as what types of workers are best suited to pursue such programs. Khmer practitioners negotiate these incoming expectations of an ideal development worker within their own lives and context. Thus, in INGOs that originate in different nations, workers articulate distinctive visions of a 'modern development professional.' Below, I examine the different types of practitioners hired by HSA and GFA as well as the work environment in each INGO.

Workplace Environment and Practitioner Backgrounds

As a national development imaginary travels through the aid chain, it shapes the characteristics of the INGO work environments in each chain and the type of practitioners each organization hires. For instance, as we will see below, since HSA prioritizes state partnership, it hires practitioners best suited to build relationships with local officials. Below, I provide brief descriptions of the different work environments and employee backgrounds at Health Services Asia (HSA) and Global Family Aid (GFA).

HSA

As discussed in previous chapters, Japan's national development imaginary centers on a strong state that can manage the economy and provide essential social services, like education and healthcare. Consistent with this imaginary, HSA's donors and Tokyo staff –all of whom are Japanese--fund HSA's primary goal in its programming to support the Cambodian state in the provision of maternal and child health services. HSA staff run multiple "training of the trainers" workshops, assisting provincial, district, commune, and village level public health officials in implementing health education and services for mothers and children. These activities create the demand for the specific worker characteristics and help construct the work environment described below.

As discussed in the previous chapter, HSA programs and partnerships breed a work culture in which successful staff are those with knowledge about the Cambodian state. HSA's director, Junko, quizzes staff on their knowledge of the governments health policies and the important officials in the Stung Treng provincial health department. In order to build relationships with provincial officials, staff spend the majority of their time in HSA's provincial

office in Stueng Treng. This means staff encounter relatively frequent blackouts and lack of A.C., creating a rather moderately-paced work environment. Work style is communal, with all staff sitting at one large table together, except for Junko and Hanako, the Japanese staff, who often work separately in Junko's office. When Junko or Hanako are present, workplace meetings are conducted in English (although on occasion clarifications are made in Khmer because Junko speaks it).

HSA maintains two levels of program staff, each with different levels of expertise. The first level staff are program managers, Boran, Samnang, and the director of program managers, Sovann, who are all male and approximately between thirty-five to fifty years old. Program managers are charged with cultivating strong relationships with government officials. Being adult males makes it easier to form relationships with influential public health officials, who are typically also males between the ages of thirty and sixty. For program managers, expertise in health is highly valued. Two program managers, Samnang and Sovan, were hired because they had experience and training in public health and nursing, respectively, and the other, Boran, was given the opportunity to train to become a doctor during his tenure at HSA. Program managers all speak English relatively well and live in Phnom Penh, driving out to Stueng Treng province on Monday and returning to Phnom Penh Friday afternoon.

The second level of program staff are called program assistants. Program assistants are required to live in and are from Stueng Treng province because it is their job to be community liaisons and provide knowledge of the local area to program managers. Program assistants are largely female and paid significantly less than managers. Assistants help health officials interact with village mothers and children at community health events, gather relevant knowledge about village community members, and make follow up visits to mothers. All program assistants are hired soon after the completion of high school or college (without medical training). There is one exception, a program assistant named Chea, who completed her midwifery training just before beginning work at HSA. The majority of program assistants speak limited English and struggle to communicate with Junko and Hanako. In addition to managers, assistants, and Japanese staff, HSA also employees two staff members to work on budgeting and accounting, a maid, and a driver. Finally, HSA headquarters staff make at least semi-annual visits to the country office in Stueng Treng.

The day-to-day work of HSA staff is filled with preparations for different training of the trainers workshops, going to an endless array of government meetings, collecting and analyzing information on mothers in the villages in their target area, and reporting on program activities and money spent. While only managers attend governments meetings, all staff work on other tasks to differing degrees, depending on their skill set. Junko translates quarterly reports written by the staff in English into Japanese for JICA. Junko occasionally meets with JICA officials to report on HSA's project, and staff infrequently go to Phnom Penh to attend professional development events at JICA or the Cambodian Ministry of Health, each happening two to three times per year.

The division of labor between program managers and assistants is hierarchical and strongly policed by managers. Program assistants refer to managers as 'lou kru' or teacher, a respectful title in Cambodia. Program managers and Junko are highly directive of assistants' daily tasks, and managers spend substantial time training assistants to do new tasks correctly, such as writing receipts for JICA. In the power hierarchy of HSA, program managers wield 'expert' medical knowledge, relationships with state officials, and English language skills, which are understood to be more valuable than assistants' local knowledge. Assistants are policed for disregarding the communication flow required by this hierarchy, such as asking Junko a question without checking with a manager first.

Managers also maintain more social capital in Cambodian society as middle class, urban men. Sovann jokes the chain of command can been seen in skin tone. Program assistants from rural Stueng Treng often help their families with farm work and, thus, are noticeably darker in complexion than managers who have only held professional jobs from Phnom Penh. The division between staff members continues into personal time, as managers spend lunch breaks and after work time only with other managers or state officials. Program assistants are also friends outside of work, posting photos of weekend outings together on Facebook. Outside of the occasional staff party, there is little socialization among members of different ranks.

In stark contrast to GFA, no Khmer staff member at HSA had experience in international development or working for an NGO before coming to work at HSA. Instead, HSA prioritizes medical knowledge or employees with limited formal education or work experience who can be educated in the organization. Moreover, approximately one-third of HSA's staff have family members who worked in the Cambodia government. For instance, Samnang's father worked for

the Ministry of Education for many years and is now an advisor to the King of Cambodia. Samnang's father had befriended several Japanese diplomats through his work and it was through his father's Japanese diplomat friend that Samnang got a job offer from HSA. In another example, Junko explains why she hired one program assistant, Mony, over more qualified candidates. Compared to candidates with a college degree and more extensive English skills, Mony has only a high school education and previous experience working as a maid. But, Junko informs me that Mony's husband works at a public health clinic and she believes upgrading Mony's health knowledge will transfer to her husband as well.

HSA staff are given access to transnational connections but only in Japan, which differs from travel to international conferences in numerous nations afforded to GFA staff. After working for HSA for five years, managers are given the opportunity to travel to Japan for training. Boran explains his six-week trip to Japan consisted of numerous JICA health education workshops in Tokyo as well as traveling around to a few prefectures to observe the operations of the Japanese maternal and child health system. Travel to Japan serves as a bonding point between managers and Japanese staff, and Junko will often ask managers to recall particular cultural sites or health practices in Japan.

Finally, almost all INGOs experience problems with high turnover. However, as, at HSA, this is more frequently a problem with program assistants. While moving up to the position of manager is possible, HSA staff report that, more often than not, assistants stay in the position only temporarily, leaving when they find a better job opportunity or have a child. In contrast, the program managers, Boran, Sovann, and Samnnang have been working for HSA for eleven, seven, and five years, respectively. In part, this is due to the fact that, unlike U.S. INGOs, which hire staff for the life of a grant project and often lay off, at least, some project staff when it is complete, HSA is committed to projects for approximately ten years, finding alternative sources of funding when one grant ends. Additionally, two years ago HSA moved from Kampong Speu province to its current program site, Steung Treng to implement maternal and newborn health activities in a new area. When it made this move, HSA kept its managers on while hiring new program assistants familiar with the new province.

GFA

As described in previous chapters, the U.S. imaginary envisions an advanced society in which the market, state, and nonprofit sector are tightly linked. The market is primary, with the

nonprofit and state playing a supportive role, filling in service gaps. Within this imaginary, GFA staff face numerous demands in the implementation of health programming. Staff need to support local NGOs that can provide health services to beneficiaries and advocate for the needs of grassroots communities. GFA employees are also required to support private clinics, and work with their Cambodian state partner. In short, GFA needs expert development practitioners that can "do it all." These numerous, sometimes conflicting, demands shape GFA's work environment and staff backgrounds.

Not unlike the development sector in Washington D.C., GFA maintains a highly professionalized work culture. Staff spend the majority of their time in GFA's three story, air-conditioned office-building in the heart of Phnom Penh, traveling occasionally to evaluate programs in rural provinces. The office is adorned with numerous posters, all branded with GFA's logo, that promote women's sexual health; outline how to successfully evaluate the needs of beneficiaries, review best practices in research, and discourage sexual harassment in the workplace (complete with the MeToo hashtag). Outside of meetings, the work is largely individualized with employees sitting in separate cubicles.

GFA hires staff that have experience working in international development in other NGOs, development research and evaluation firms, bilateral agencies, and multilateral agencies. GFA's hiring practices align with studies that show NGOs are more likely to hire middle class, educated, and urban workers (Lemay-Herbert 2020). The approximately fifteen full-time staff members[29] on the USAID program are organized into two teams: programming, and monitoring and evaluation. Then, there is also a staff member charged with the budget, a research coordinator that bills part of her time to the project, a communications officer, and the health behavior change project director, called a chief of party. Finally, GFA's director, Ranny, and deputy director, Erin, also spend 60 to 30 percent of their time on this project, depending on the week. Of the staff, the chief of party and deputy director are foreign, while all other staff are Khmer. Headquarters staff make frequent visits to assist with different technical aspects of the project, such as setting up a database for GFA's government partner. Finally, while GFA is the

[29] Recall from previous chapters, the USAID project is just one of several projects GFA is implementing. GFA maintains almost 50 staff members in total. Other staff members would sometimes be pulled into bill a smaller percentage of the time to the project. Such a practice is commonplace in large INGOs with USAID contracts.

lead organization on the project, the USAID project will also be implemented in partnership with two partner organizations, another INGO and a private consulting firm.

The work culture is cordial, professionalized and relatively independent. All meetings are conducted in English and all staff are fluent. GFA employees are often quite busy, rushing to complete the next activity on their list. This environment is spurred on by Erin, the American deputy director, who demands a fast-paced work environment. She believes that Cambodians will "mosey" if allowed, taking naps and two-hour lunch breaks (it is traditional in Cambodia to nap after lunch). Erin often enters meetings to speed up conversations or visits staff in their cubicles to ask when their work product will be complete.

At GFA, hierarchy matters, but to a much a lesser degree than at HSA. Staff at GFA are approximately 50/50 male-female and both men and women fill managerial roles. There is great respect given to GFA's Khmer director, Ranny. Moreover, program and evaluation team members are given direction on their daily or weekly tasks from their team directors. Staff refer to one another as "bong" (literally translated as sibling), a sign of friendship and equality in Cambodia. With the exception of the deputy director, director, and chief of party, project staff spend personal time together outside of work, regardless of rank or team.

The day-to-day tasks of GFA project staff are more varied due to the numerous stakeholders with whom they need to interface. They include activities like planning for numerous workshops and meeting with diverse partners. Staff also need to complete tasks like selecting private research consulting firms to collect project data and analyzing that data, planning project activities and selecting local NGOs to implement them, evaluating local NGOs, attending government meetings (although to a lesser degree than HSA), meeting with USAID at least once per month, attending professional development or informational workshops held by other INGOs and donors, traveling to provinces to meet with local leaders or private clinic partners, writing and designing reports for each workshop conducted, and following the complex budgeting and reporting procedures of USAID.

The director of the program team is a doctor who previously worked on numerous INGO health programs and the chief of party is a specialist in public health and international development. All other practitioners do not specialize in health but have previously worked for other development organizations. This is true with the exception of one program staff member, Sophal, who had worked for GFA for almost ten years, starting as a driver and rising up through

the ranks. GFA's director, Ranny informs me that in her hiring process she values credentials and NGO experience, and that she tries to hire women when possible.

GFA staff are given numerous opportunities to travel and create transnational connections, although these opportunities differ depending on their role in the organization. Program staff go to international conferences on program topics such as women's health or are sent to observe successful USAID projects in neighboring nations. Monitoring and evaluation or budgeting staff attend professional development workshops at USAID mission offices in nearby nations or sometimes travel to Washington D.C. to learn more about USAID rules and regulations. Occasionally, staff get the opportunity to travel to other kinds of professional development workshops, such as women's leadership conferences, which can happen all over the world. Finally, GFA faces considerable issues with staff turnover. GFA, like most other organizations that implement USAID projects, works on a project-based model, hiring staff to implement large donor projects for four or five years and laying off staff at the competition of the project. Temporary employment means skilled staff are always on the lookout for their next job. Thus, in pursuing their distinctive programs and partnerships, HSA and GFA hire staff with different backgrounds and maintain distinctive organizational environments.

Practitioner Identities, Gendered Beliefs, & Organizational Tensions

In this section, I will discuss two consequences of the above differences in hiring practices and workplace environments. First, I examine the impact on practitioner's professional identities and the meanings they ascribe to their work. Second, I will analyze the effect of each workplace on Khmer practitioner's gendered beliefs and the different types of organizational tensions that arise in each environment.

Practitioner Identities

Practitioners ascribe varied rationale and meanings to their work. Almost all development workers say they want to "do good" but this desire coincides with other motivations and career aspirations (de Jong 2011). Experiencing distinctive workplaces, the professional identities of practitioners at HSA and GFA vary, as do their motivations for their work.

HSA.

When asked directly, "why do you do this job?" HSA staff will provide rationales like "I want to help poor women and children" or "we are helping the poor mothers." However, altruism is not the only reason individuals choose this work. Having different backgrounds and

organizational roles, program managers and assistants at HSA ascribe slightly different meanings to their job. First, as discussed in the previous chapter, due to HSA's state partnership objectives, program managers, Boran, Samnnang, and Sovann, spend an inordinate amount of time building positive relationships with government officials. Sometimes managers, particularly Sovann, push back on this directive. Sovann reports that he thinks it's important to support the government staff but he also wishes "they could help the mothers and caregivers more directly like other NGOs." He believes if HSA did both, they could disperse even more information about maternal and children health.

Nevertheless, program managers do find building relationships with government officials to be meaningful and useful work. After he returns from a district meeting one day, Sovann explains it is a manager's job to work closely with officials at different levels of government (provincial, district, commune) and "figure out who has the power, who is the person who can change things, how can we work with them, who will really implement, and then we teach them all about the importance of the maternal and child health issues." Many officials are "not well-informed about the national policies" and "it is our job to inform them, but we cannot just tell them… if they don't know us, they won't listen." Boran tells me he found such work difficult at first as, when he was younger, he was nervous about treating government officials as his friends. However, now he goes out drinking with them, they act as equals, he can tell them about what he has seen in Japan and the Cambodian Ministry of Health's policies, and he feels this can make a difference. For Boran and the other managers, having respected public officials treat them as an equal and listen to their advice is rewarding in and of itself.

Second, as program assistants are not forming the same close relationships with government officials and come from different backgrounds, they ascribe different meanings to their work at HSA. Program assistants often tell me they like their job for the opportunity to learn technical skills that can advance their future careers, such as computer use and English. Additionally, while all INGO staff work to support their families, for assistants at HSA the opportunity to earn extra or supplemental income for their families is particularly important. Their pay is limited compared to managers, in part due to the expectation that assistants are Stueng Treng residents living with their families. All but one assistant (whose family had died) lived with their family of origin or were recently married. The majority spent their time away from work assisting family members with farming tasks. Yet, since agriculture does not provide

a consistent monthly income, regular payments from an NGO job enhance the livelihood of assistants' families.

Program assistants value that their position at HSA both allows them to aid their fellow community members and support their families, but also that it upgrades their status in the surrounding community. Working for an INGO affords assistants a newfound respect in their communities. Unlike managers, program assistants are likely to stay in Stueng Treng. Through their work, assistants get to know villagers in HSA's target areas. They call village leaders ahead of time to organize events, gather information from village chiefs and volunteers, arrange meetings with mothers, and talk warmly with participants and village leaders at HSA community events.

Assistants are also provided with access to HSA's cars, tablets, and cellphones-- symbols of status in Stueng Treng. Aiding program managers in implementing health trainings, assistants are called lou kru or naek kru (teacher) by mothers and other villagers. One assistant, Chhy, explains that when he hears other villagers, even older villagers, call him teacher, "I feel so good… I do not know if I deserve it… but I feel so good when I hear them say this." Thus, program assistants find the job meaningful for their ability to build their own reputation and status in their community. Thus, although *who* they build relationships with is different, a key meaningful aspect of HSA work for both managers and assistants is relationship-building. Program managers and assistants find the work of improving health knowledge of state officials and community members meaningful, but they also appreciate the status afforded by such connections.

GFA. GFA practitioners also believe it is important to help their fellow Cambodians. However, outside of this similarity, GFA staff maintain distinctive motivations and ambitions from HSA employees. All Khmer staff on the USAID project team are over 25 years old. The majority are married with children, with the exception of two women who are still single and living with their family of origin. While GFA staff work on different teams, such as monitoring and evaluation or project management, there is not a significant difference in the motivations of different types of workers at GFA. GFA staff are committed to working hard to help others, but also appreciate that their job allows them to achieve middle class, cosmopolitan status in Phnom Penh. While HSA program managers are also middle-class Phnom Penh residents, due to their

distinctive organizational environment and backgrounds, they did not express the same meaningful connection with an identity of cosmopolitan development practitioner.

Employment at GFA permits staff to work in an office, dress in professional clothing, and maintain a five-day work week, all important markers of a middle-class and "modern" lifestyle in Cambodia. GFA practitioners are committed to upward mobility, and to support their families in achieving urban, middle-class status. Women in the office often compliment each other on new name brand purses or outfits. Male workers save up to purchase status symbols such as phones, cars, or watches. One budget manager, Kunthea, whose mother and father sell goods in the open-air market, informs me that her parents are very proud she has an office job, dresses professionally, does not work outside, and eventually, will help take care of them.

All married staff members at GFA, male or female, are in couples where both partners work, a necessity to maintain their middle-class lifestyles. Spouses have a variety of jobs such as banker, doctor, development professional, hotel manager, tailor, restaurant owner, and one government official. At lunch one day, a coordinator on the monitoring and evaluation team, Sreyna, tells me it's important to her to maintain this lifestyle so her kids, who go to private school and after school lessons in Chinese, can do even better than she has.

Committed to middle class lifestyles, GFA employees worry about the insecurity entailed in INGO work. As Chantrea's story in the introduction to the chapter shows, GFA workers often worked previously on several short-term grants at different INGOs. Typically, after getting a large bilateral or multilateral grant, INGOs hire new workers. But, after the completion of that grant, many of those new workers are laid off. For instance, the monitoring and evaluation specialist at GFA, Panh, previously worked on USAID projects at three other INGOs. At GFA, 60 percent of the USAID project staff had been hired on just for that project.

Staff lucky enough to have worked at GFA for more than four are five years are often shuffled from one grant to another. For instance, a member of the program team, Sophal, informs me that he previously worked on a malaria and a family planning project at GFA, until those grants ended. Then, he was switched to the new USAID project. However, he still worries that if GFA doesn't get another big grant, he may have to "take a break" or "look for a new place." This funding insecurity causes GFA staff to be constantly on the lookout for their next job. Job moves are facilitated by the close-knit networking of INGOs in the Cambodian development sector, as INGO staff often cooperate with one another, meet at conferences, and share data. Most GFA

practitioners express that their family absolutely cannot maintain their current lifestyle without their income.

Thus, the national development imaginaries of Japan and the U.S. shape INGO activities as well as the work environments and hiring practices at HSA and GFA. Yet, these national imaginaries gain new implications as Khmer practitioners ascribe meanings to their work within the context of their own lives and nation.

Gendered Beliefs & Tensions

The hiring practices and work environments of HSA and GFA also have gendered consequences. Organizational understandings of an ideal worker often entail gendered assumptions, such as the belief at HSA that because government workers are male, men are best able to build relationships with them at HSA (Acker 1990). Furthermore, HSA and GFA maintain different organizational practices around the global norm of gender equality. Chapter Four introduced these differences and illustrated how it impacts programming, but here, I will show that it also shapes the self-understandings available to practitioners. Below, I first discuss how the gendered beliefs of practitioners are influenced by each work environment and second, I examine the very different gendered tensions that arise in each organization.

HSA.

As discussed in Chapter Four, at HSA there are no workshops on gender equality for staff, or any discussion of gender norms. Following the Japanese imaginary, HSA does not "not intervene in Cambodian culture" and staff do not explicitly discuss the place of women and men in society in program implementation. In consequence, HSA program managers and assistants largely espouse what Samnang calls "traditional" Cambodian beliefs about gender and family life, expecting women to take on the majority of household duties and men to earn more money. The very division of labor at HSA reinforces gendered power dynamics as male program mangers all have some form of medical training and live in Phnom Penh while program assistants are largely female, lack specialized training or English language skills (with the exception of one midwife), and all come from the province where HSA implements programs.

Program managers express two reasons for 'traditional' beliefs. First, as described in Chapter Four, it is strategic, allowing them to form better relationships with influential government officials. Second, for program managers many 'traditional' beliefs about the roles men and women should take in society hold true in their personal lives. One day, while eating lunch, Samnang and I discuss his upcoming nuptials. He explains to me his fiancée will

definitely not be a “modern wife” like me -- traveling out to Stung Treng unaccompanied each week with three male program managers and their driver makes me ‘modern’ in his eyes (in Cambodia, women do not traditionally travel alone). Samnang says his fiancée will be a “Cambodian wife” who takes care of the house, the kids, and cooks his favorite meals like “samlaw koko” (a tasty Cambodian soup) while he travels for work. Although, when I ask about her job, he laughs “of course, she will work.” His fiancé must also keep her job at a bank in Phnom Penh for “family stability.”

Boran and Sovann are both already married and maintain similar perspectives when asked about their families. Sovann says he misses his kids but it is his wife’s job to care for them and his to earn money for the household. Similarly, when I inquire about their future, with the exception of Sopheap and Chea, who want to further their careers first, most female assistants express the desire to get married as their foremost concern. As we saw with program outcomes, HSA’s noninterventionist stance in relation to Cambodian gender norms largely leaves staffs’ explicit beliefs about gender and assumptions about the responsibilities of women and men in society unaltered.

However, these gender norms do not go without any pushback at HSA. Despite her unwillingness to discuss gender directly, Junko does try to undermine these processes to some degree in the sense that she does not strictly adhere to gendered expectations in her own life. Now in her late fifties, Junko left Japan in the late 1980s to study to be a nurse in Hawaii. As Japanese public interest in Cambodia was growing at this time, Junko decided to go into aid work, and was stationed at a Cambodian hospital in Phnom Penh starting in the 1990s. When Phnom Penh became too developed, she moved to a hospital in Siem Reap. She started working with HSA four years ago. Unlike other Japanese directors I interview, who typically come from headquarters and stay in Cambodia around three to five years, Junko lives in Cambodia permanently and speaks Khmer. She is also married to an American. She describes Japan fondly, particularly in terms of the food and landscape, but she also explains that Japanese people are “very polite,” “they have certain expectations,” and it is easier to live in Cambodia without these expectations. Leaving Japan in the 1980s, Junko bucked gendered traditions of her time with the decision to live and work internationally, as we well as to not have biological children. Furthermore, while the adoption of children is not widespread in Japan, Junko and her husband also adopted a Southeast Asian child (The Nippon Foundation 2018).

At least to some degree, Junko is also aware of the impact of traditional gender norms in her organization, particularly in the relations between program managers and assistants. To combat what she describes as "the hierarchy problem," Junko hired two male program assistants and a female assistant with medical expertise, Chea (the midwife). After they were hired, program managers did substantial work to reestablish the hierarchy. Compared to the original female assistants who are high school graduates, managers rank male program assistants and Chea, who are educated, as 'higher' than the original assistants, but lower than the managers.[30] For instance, Sovann writes the position of everyone in hierarchical order on the board, explaining the roles of managers and assistants and reinforcing the 'chain of command' to the newcomers.

Junko also takes a special interest in female assistants who want to upgrade their technical skills and further their careers. She requests that Sovann teach Sopheap to drive when she expresses interest in it and asks me to tutor Sopheap and Mony in English to build their skills to the level of the managers. Sopheap works hard to upgrade her skills. One day, challenging the masculinized hierarchy of the organization, Sopheap tells me quietly that she hopes "women can be managers."

Unsurprisingly, at HSA, a key organizational tension arises from the fact that the program managers are all males who express traditional gendered beliefs, yet work in an organization where the leadership, Junko and Hanako, is female. Junko and Hanako understand upgrading the capacity of their Khmer staff to be a key part of their jobs. Upgrading the capacity of the managers includes improving their managerial, reporting, and professional skills. To do so, Junko and Hanako employ many different techniques. For instance, Hanako helps program managers and assistants write receipts and budgeting forms correctly, checking their work carefully. Junko also offers advice to managers on how to manage assistants.

Boran, Sovann, and Samnang do not openly contradict Junko or Hanako but they resist this capacity-building in several ways. One day, a visiting headquarters staff member, who is female and about thirty years old, checks Boran's report and makes numerous corrections in front of the whole staff. After she walks away, Samnang asks Boran (in English to ensure my understanding), "you're the head manger, why do you need to take orders from a little girl?" In

[30] One of the male program assistants is also gay, and managers use disparaging comments about this to re-establish the hierarchy as well.

another example, Junko downloads a typing program and insists to Boran that he use it to learn to type faster in English. He agrees but when she goes back in to her office, the managers look at one another in annoyance and he does not use the program.

Boran, Samnang, and Sovan also rationalize working for women by explaining to state officials, assistants, and one another that their 'real boss' is in Japan. This real boss they refer to is a Japanese male, Dr. Nagao. Dr. Nagao is one of the founding members of HSA and comes to visit the Cambodian office on occasion to assist in program implementation and evaluation. The program managers have all met Dr. Nagao and they praise him as a mentor, respectful, and intelligent. Samnang directly compares his leadership style to Junko's, "she is authoritarian and he is gentle."

Finally, like most NGO workers, HSA staff face strict budgeting obligations around their daily activities, reporting how much spent on transportation, submitting receipts for workshop items, and writing detailed receipts for all money distributed to state officials. Due to funding priorities and limited resources, HSA does not provide staff with annual retreats or gifts on holidays, such as Khmer New Year, which is common practice for other INGOs[31]. HSA hosted only small dinners on occasions such as a long-term staff member's departure or holidays. Yet, in order to build positive relationships with public health staff, HSA is generous with state officials, paying them per diem and supporting public events.

These budgeting priorities, although largely decided by HSA headquarters and JICA, heighten the tension between managers and foreign staff. One day, two female headquarters staff members are visiting and we have a meeting about employee benefits. There, Samnang demands to know why HSA supports government officials' per diems but won't have a retreat for staff. The headquarters staff members look confused, as this proposal is clearly foreign to them; one inquires, "where would the budget for that come from?" The other employee from headquarters, who previously worked in the Cambodia office, tells me privately, "we should put the capacity of the staff first… teaching them is also important." But, she laments that leadership at headquarters and JICA prioritize relationships with state officials.

Yet, all of the male program managers interpret the resistance to doing things like providing staff retreats as evidence of the fact that "women are bad patrons," assuming the

[31] Staff are provided with other benefits uncommon in the INGO world, such as coverage of up to two hundred dollars in medical expenses.

Japanese staff simply do not want to provide them with the benefits they feel they deserve. Samnang goes so far as to compare the financial practices of HSA's leadership with communism, a harsh insult in Cambodia where communism is associated with the violent Khmer Rouge regime. In resistance, managers often attempt to "get what they can" out of the situation. For instance, in driving back and forth to Phnom Penh, we often pick up and drop off numerous items, including furniture, food, animals, and plants for managers' extended kinship networks and for sale. Junko is aware of this practice but largely ignores it.

At HSA, Japan's development imaginary is reflected in activities that promote the hiring of permanent male staff to build inter-personal relationships with state officials and less well-paid, often female, assistants to support communities. Such hiring practices echo the Japanese breadwinner model discussed in Chapter Three, but they are also made meaningful within managers' "traditional" Cambodian gender beliefs. However, this model is interrupted by Japanese female leaders at HSA, resulting in tension and resistance.

GFA. At all USAID funded INGOs, it is necessary for staff to, at the very least, pay lip service to the need for women's empowerment and gender equality. GFA staff have numerous conversations about gender equality and the roles of men and women in society, not only relating to programming but also in their work environment. First, GFA staff have annual professional development workshops directly discussing gender and their work environment, touching on topics like sexual harassment or the importance of equal male-female representation in management. Second, GFA staff report they often have 'gender sensitivity' trainings in which they learn how to integrate topics like gender equality, women's empowerment, or LGBTQ+ issues into programming.

However, due to the numerous and varied work tasks described above and in previous chapters, gender equality is simply one of many concerns at GFA, putting serious constraints on the amount of time staff can dedicate to gender issues in program construction, evaluation, and internal organizational dynamics. GFA engages with gender issues in a limited or constrained way due to numerous other responsibilities. However, while this does not permit the in-depth engagement with gender we see in NGOs focused solely on gender equality, it does allow interested staff the space to encounter ideas on the topic and form new opinions.

When I arrive at GFA, the director introduces me, letting everyone know I am doing a research project on NGOs, health, and gender. Staff nod in familiarity. Thus, when introduced to

me, staff immediately tell me what they assume I want to hear – they are committed to "gender." However, as I spent more time at GFA, I discover that the gendered beliefs of staff vary as practitioners put the schemas available to them for understanding gender together in distinct ways. A few staff members outright reject gender equality norms. For instance, GFA's monitoring and evaluation expert, Panh, informed me that "culture could not change" and "gender is pushed on us from the U.S."

Other staff are deeply committed to transforming gender relations within Cambodia. For instance, Sophy claims "we can be Khmer and challenge the idea that women have to do all the cooking, cleaning, and childcare. Women work for the family too and they deserve to go out with friends too!" Yet, the majority of GFA staff express mixed beliefs about gender. Most GFA employees believe that being an expert development professional requires challenging 'traditional' gender norms in programming and their own lives to some degree. At the same time, many employees worry gender is a "foreign import" and don't want to let it change Cambodian culture too much. This means at GFA staff do not simply enact incoming gender equality norms but creatively combine ideas about gender that they see as "foreign" and "Cambodian" in different ways.

For many male workers, exposure to ideas challenging gendered household norms make them realize the importance of helping around the house and "not putting it all on women." For instance, Arun explains that he wants to allow his wife to be a "good mother" because it is what she always wanted. At the same time, he says he now knows that it is "his duty" to help her around the house in any way he can. In another example, Chantrea explains her husband, who is also a development worker, tries to do an equal amount of labor when it comes to cooking and cleaning the house. However, they have both agreed that when his mother comes to visit, he won't help since his mother shames Chantrea for allowing him to do so.

Furthermore, GFA's director, Ranny previously worked for on numerous activities encouraging gender equality in her previous jobs at a women's empowerment INGO and a bilateral agency. Ranny also weaves together "Cambodian" and "foreign" understandings of gender, explaining the need to attain gender equality within Cambodian traditions. For instance, she proudly tells me about the time she had to go up against the owners of Heineken in her previous job at a women's empowerment INGO. Heineken owns a well-known beer brand in Southeast Asia, Tiger Beer. At this time, Tiger Beer required female distributors known as 'beer

girls' that work at many popular restaurants around Phnom Penh to wear only very small skirts and bras at work. The INGO sent Ranny as a spokesperson to the Heineken corporate meeting. Ranny describes being terrified as she went up to the Heineken board, filled with white men in suits, to give her presentation. She thanked them for providing job opportunities to women but explained that the required outfits are not culturally appropriate for Khmer women; while to a Westerner it might seem like empowering women's sexuality, in Cambodia it is not seen that way. She noted that beer girls are harassed and argued that they need to be given a full dress (notably, Tiger's beer girls now do wear full dresses, although they are still quite short by Cambodian standards). Ranny combines narratives of female empowerment in the workforce with understandings of cultural appropriateness in the Cambodian context.

This desire to combine "foreign" ideas about gender equality, particularly the idea that men and women should be equal in the workforce, and understandings of a good Khmer wife and mother creates a key tension at GFA, specifically for female practitioners. One space where practitioners face tension combining a successful professional life and "traditional" family expectations is childcare. For instance, a program staff member, Sreyna and her husband work in Phnom Penh but their jobs do not pay enough to afford childcare for their two young children. They leave their children with her husband's parents in Takeo province each week, traveling to see them on weekends. Sreyna's in-laws make her, but not her husband, feel guilty for not being with her kids each day. Due to guilt, she tried taking a job at a small NGO in Takeo. However, Sreyna found this job "boring, repetitive, and unprofessional," compared to fast-paced INGO work in Phnom Penh. Sreyna reports she had to find another job back in Phnom Penh: "I like the work, I like the clothes, I like the lifestyle here… I just couldn't stay out there…. I felt like I wasn't successful in my career anymore."

Chantrea also says it's really difficult to be a good mother, a good wife, and a good development professional. She recently had a baby and daycare is limited and too expensive in Phnom Penh for her and her husband to afford. Her parents can care for her child but they live on the outskirts of Phnom Penh on the complete opposite side of town from Chantrea and her husband's home (only expatriates, wealthy business people, and political families can afford to live in Phnom Penh proper). So, to solve this problem, Chantrea and her new baby stay with her parents during the week while her husband and son stay at their house. She only sees her immediate family on the weekends.

At one point, Chantrea is asked to travel for three weeks to three different provinces to conduct monitoring and evaluation research in local NGO implementing partners. Chantrea tries to express to her manager, Panh, that this is a difficult time for her to make a field visit but Panh informs her such visits were in her job description. Yet, the need to travel adds stress on top of her already trying childcare arrangements. To make the trip, she will need to stop breastfeeding early, although she has been doing so for only eight months and she had planned to breastfeed for a year. Additionally, she feels her husband is worried by and her mother is angry about Chantrea's need to travel for work. In part, this is because the previous year when Chantrea traveled to the field with a different INGO, she was in a serious car accident; the car Chantrea was riding in flipped, the driver was killed, and Chantrea's arm was crushed. She traveled to Thailand for surgery but the mobility in her right arm is permanently impaired. Chantrea worries that frequent travel by car to the field isn't safe, as many NGO workers experience car accidents. Additionally, she explains that in Cambodia a 'good woman' does not travel alone and a 'good mother' does not leave her baby, although both are often required of INGO professionals.

These problems are eerily similar to many Western women's struggles to balance work and family in professional jobs, albeit in a very different cultural context. Unsurprisingly, due to the U.S.'s own limited family policies (discussed in Chapter Two), the hiring practices arising from the U.S. development imaginary assume male and female workers are equal, while ignoring the particular demands women face as caregivers.

Despite these similarities, Khmer practitioners often make sense of their difficulties by juxtaposing American and Khmer female staff. GFA has two permanent American employees. The deputy director and a public health expert on the malaria team. Both are female. Additionally, headquarters or regional office technical experts visit the Cambodia office often. All headquarters staff that I encounter are American, have at least five years of experience working in the international development sector in other INGOs or private evaluation firms, and two of them entered development work after serving in the Peace Corps. All have advanced degrees in public health or international development. Khmer staff often point to these women (and myself) as examples of 'modern' women who can travel easily to the field, "with no care for their families." Sreyna, reports that travel to the field can be fun, rewarding, and we can see how people really live. However, travel is not easy for Cambodian women. "We are expected to

be with our families." In contrast, American women are portrayed as unobligated by familial expectations and, by extension, lacking in family closeness or kinship networks.

At GFA, no male worker expresses similar concerns about childcare or anxiety around travel, despite the fact that all male staff members have children. Male practitioners often describe traveling to the field as "inconvenient." They note "their families miss them," and sometimes, they express concern about their wife thinking they are cheating while traveling for work. Nevertheless, for male staff, it is assumed their female partner will handle the childcare without difficulty in their absence.

In the U.S. development imaginary, women will gain empowerment from entering the formal workforce, yet, as in the U.S., the struggles of combining work and parenting are rarely addressed. Female practitioners feel that they must remain silent on this topic to compete on equal footing with male co-workers. Additionally, even when female practitioners discuss their difficulties combining work and family with their bosses, managers have little leeway to accommodate them. Such a tension does not arise at HSA, as program managers who travel for work are male.

Divergent Visions of Modern Development Professionals

Above, I have illustrated two processes. First, I showed how the development imaginaries in which HSA and GFA are embedded carry implicit assumptions about the type of worker best suited to advance recipient nations. This results in distinctive hiring practices and work environments. Second, as we have seen, this articulates through Khmer practitioners' own self-understandings, meanings, and the workplace tensions they encounter, producing distinctive identities, gendered beliefs, and organizational tensions. In this concluding section, I analyze how practitioners' future career ambitions illustrate the divergent visions of modern development professionals inherent in each organization.

HSA

The majority of HSA practitioners have future ambitions to work in the public sector. Like Samnang in the beginning of this chapter, all program managers and two program assistants see HSA as a stepping stone for moving into government careers. Such a move is made smoother by the friendly geopolitical relations between Japan and Cambodia. For Sovann and Boran, it was not until after working at HSA and making friendships with officials that they began to see this as a possible career move. Sovann thinks working in a district health department is an

appealing career move so he would no longer need to travel each week. Before coming to HSA, Samnang, whose father is a high-level government employee, planned to eventually work in either the Ministry of Health or the Public Health division of the Ministry of Education in Phnom Penh. He believes working for HSA before moving into the public sector will build his social network and allow him to "see how people really live in the community."

For program assistants, a move into government work is less obvious but still something to which several aspired. Sopheap, who had been a program assistant for almost a year, thinks her improved status in the community helped to build her confidence that she could achieve her dream of working in public education. With midwife training, Chea eventually wants to become a midwife at a public health clinic. Relatedly, Chenda reports that while she originally took this job to earn extra income for her family, she also thinks that by gaining respect in her community, she might be better able to find a good husband, like a public health worker.

While it is not the stated intention of Tokyo staff to produce new state officials, the state is understood to be the sustainable implementer of development at HSA. This articulates with the lives and options of Khmer workers with the result that many employees envision a future as public workers. At HSA, the modern development professional that can advance Cambodian society is an implicitly male state official who effectively implements public services and aids Asian families. HSA staff can use the social contacts with government officials fostered by their job to move into government job in their future careers.

GFA

In contrast, most GFA staff envision career advancement within the international development sector. It is not unheard of for U.S.-based INGO workers to move into government careers, particularly just after the UNTAC era in the late 1990s and early 2000s, when there were a limited number of skilled workers in Phnom Penh. However, with the current geopolitical relations between the U.S. and Cambodia, it is rare for workers from U.S.-based INGOs to do so. No GFA worker expressed a desire to move into government work in the future. One worker wants to start her own clothing store and another is considering moving into microfinance. All other GFA staff on the USAID project saw their future within the development field.

In contrast to HSA but consistent with the U.S. development imaginary, INGO workers at GFA are considered legitimate experts in generating societal development, as nongovernmental actors cooperate with the state and private sector in providing social services. A number of GFA

practitioners wanted to move up to bilateral or multilateral agencies that paid more and offered permanent positions. For instance, Kunthea started her career at a local NGO, moved to a smaller private USAID contract firm, and then, moved to her current role in budget and contracts at GFA. She explains to me that she wants to keep gaining skills at GFA that will eventually allow her to move up into a bilateral agency, like USAID or DFAT (the Australian bilateral agency). Other staff members express ambitions to become INGO directors or deputy directors, which would afford them more secure employment status and higher salaries. GFA staff aspire to lives as cosmopolitan development practitioners, imagining an ideal future in which Phnom Penh could be a hub of international development in Southeast Asia, similar to Bangkok. Thus, at GFA, the inherent vision of a modern development professional and the aspirations of practitioners articulates into an ideal vision of an expert development practitioner. Becoming such a practitioner also entails advancing global norms, like gender equality, in a practitioners' work and home life.

In conclusion, this chapter expands studies of meaning and NGO work. NGO practitioners are not simply activists, global professionals, altruists, or resistant workers under neoliberal constraints. As sites of transnational work, INGOs promote different, gendered visions of a 'modern development professional' who can contribute to the development of their nation. However, these visions vary. As we see above, due to the development imaginaries in which they are embedded, HSA and GFA have distinctive expectations of the workers who can enact their vision of a modern society, and Khmer workers articulate these expectations within their own lives and ambitions.

Chapter Eight
Conclusion

This dissertation has explored national variation in global aid chains, the set of relationships linking donors, INGOs, and local development practitioners. Engaging the large literature documenting the key role that INGOs play in transmitting global norms, I focus on how organizational and individual actors adapt those norms in recipient contexts, underscoring the importance of variation due to INGO nation of origin. Chapters One and Two illustrate how the political histories, diplomatic priorities, nonprofit cultures, and gendered health policies of the U.S. and Japan, respectively, manifest in distinct national development imaginaries. These imaginaries reflect dominant schema for understanding the role that governments, markets, and civil society should play in development. Practitioners embedded in national development imaginaries in Washington D.C. and Tokyo create and fund distinct programs and pursue different practices, which influence the organization of each aid chain. In the second part of the dissertation, I show how these programs and practices articulate in the Cambodian context, with distinct outcomes for women's health programming, NGO-state partnerships, and practitioner identities. Altogether, this project demonstrates that what flows along global aid chains is not just money and material aid, but also contending ideas about the role of the state, the market, civil society, and gender in the development process.

Differences in the national development imaginaries of the U.S. and Japan are particularly important in light of current geopolitical transitions. The World Economic Forum predicts that by 2030, the U.S. will no longer be the largest economy in the world, raising questions about its continuing status as the global hegemon.[32] China, as well as Japan and South Korea, are increasingly important players on the global scene, vying for influence and offering new models of development (Greenhill, Prizzon, and Rogerson 2016; Stallings and Kim 2017). In this conclusion, I ask what these geopolitical changes mean for international development and INGOs. To begin to consider this question, I examine the life history of Rith, who was previously the director of the local NGO in this study, Cambodian Development Society (CDS).

[32] https://www.weforum.org/agenda/2016/11/8-predictions-for-the-world-in-2030/

Rith was born in the 1970s to a farming family in rural Kampong Speu. As a young person, Rith lived through the political changes at the end of Civil War and the UNTAC era, and, like many Cambodians of his generation, is incredibly resourceful, flexible, and entrepreneurial. As Rith came of age and his country was rebuilding, he decided he wanted to upgrade his family's agricultural life. Thus, as a young man, he became a monk, a way of bringing great merit to one's family in Cambodia. He remained a monk for a number of years, learning Buddhist principles as well as how to read and write in English. Then, in the late 1990s, during the UNTAC era, Rith noticed the influx of foreign aid funding for NGOs. As a monk, Rith wanted to help his community and his country, and was considering starting an English school. In the late 1990s, after traveling to Phnom Penh and visiting a number of successful local NGOs, he decided to leave the monkhood in order to found a local NGO, Cambodian Development Society (CDS).[33]

CDS began as a small English school and shelter for poor children. But, Rith was persistent, traveling to Phnom Penh and Siem Reap to build networks with international donors. He turned out to be quite savvy at gaining funding. By the late 2010s, CDS had a budget of almost one million USD, implementing numerous education, health, and microfinance projects. The NGO's donors include INGOs, universities, companies, individuals, and bilateral donors in the U.S., Europe, and Australia. When asked about his decision to found CDS, Rith explains, "I wanted to help my community, my family, and my country prosper and, at that time, an NGO was the way to do it." Prospering as an NGO director, Rith married and bought a hotel in the city of Kampong Speu, which his wife manages. His family is now well-off by Kampong Speu's standards. He dons middle class status symbols, often wearing a nice watch and a suit, a far cry from the orange monk's robes in which he began his career.

At the time of my research, with the help of his Scandinavia donors, Rith had also recently opened a new social business, a hotel and yoga retreat that would support his NGO by generating revenue from tourists and provide vocational training for poor youth. He ran CDS and this social business, while continuing to always be on the lookout for the next funding opportunity. Yet, during my time at CDS, Rith tells me he is considering making a change because finding NGO funding is "not like it was ten years ago." Since Cambodia was reclassified from a low income nation to a lower middle-income nation by the World Bank in 2016, NGO

[33] As monks are not allowed to deal with money, he could not remain a monk and direct an NGO.

funding from Western donors is decreasing. Rith believes that to continue to help his family, his community, and his country develop, a new strategy is needed.

He is thinking about starting a new business drawing on expertise and contacts he developed in the course of his NGO work. Specifically, in the process of pursuing his idea to open the yoga retreat, Rith received support from INGOs to attend trainings on how to run a business and other business networking events in Phnom Penh. At these fora, Rith started networking with businessmen from China and South Korea and he now hopes these networks will be useful as he pursues a new commercial venture. During my time conducting participant observation at CDS, Rith nominated a deputy director, who he plans to train to take over the NGO when he starts his own business.

Approximately two years after my departure, I learned that Rith succeeded in his plan. He is now the CEO of his own company, with a Chinese businessman as his partner. As Rith is highly skilled at social networking in Cambodia and his investors have connections to Chinese companies, the company takes advantage of the numerous infrastructure development loans China provides to Cambodia. Rith's shift from NGO director, networking with Western donors, to the CEO of a company with Chinese investors represents a larger transformation taking place in Cambodia. Alongside the geopolitical shifts described above, Cambodians are reimagining what development means and the best way to pursue it in their personal lives and in their nation.

Shifts in the Global Order?

As discussed in Chapter Two, the U.S. has been a dominant world power since the 1940s (Inkenberry 2005; Mann 2003). After WWII, the U.S. provided the majority of foreign aid funding to Europe for rehabilitation and played a prominent role in reestablishing the global economy. At this time, the U.S. gained lasting influence in the work of the World Bank and the International Monetary Fund. In the 1980s, those international banks assisted the U.S. in making the Washington Consensus and its neoliberal policies the dominant economic development model around the world, employing rhetorical commitment as well as coercive mechanisms, like structural adjustment loans (McMichael 2016). Moreover, with its foreign aid regime beginning during the Cold War, U.S. aid has historically emphasized global capitalism and democracy, priorities which have had a lasting impact on today's global development norms.

However, several events in the early 2000s created doubt about the U.S.'s place in the world order. These included first, the 2001 terrorist attacks and their aftermath and second, the 2008 financial crisis (Inkenberry 2005). In contrast, in the beginning of the twenty-first century, new models of economic development were on the rise in Asia. Japan and South Korea had been hailed for their rapid economic ascent as prominent examples of successful developmental states (Chu 2016). Furthermore, many Asian nations, such as Singapore and South Korea, weathered the 2008 financial crisis better than their Western counterparts.

More recently, China is rapidly becoming a global economic powerhouse and influential global actor, challenging the U.S.'s monopoly on global power (Ciccantell and Bunker 2004). Scholars and policy-makers debate whether or not China will become the next global hegemon, or if the world is moving towards a more multipolar global order (Ciccantell and Bunker 2005; Inkenberry 2014; Songchuan and Shulong 2011). Whatever the outcome of these larger geopolitical shifts, what is important for this project is that alternative models of development have been produced by East Asian nations, like the developmental state. Such models provide a counterpoint to the dominant development norms produced by the U.S. and other Western nations, enabling new ways of thinking about development (Stallings and Kim 2017).

An Asian Development Model?: New Visions and Contestations

Above I have detailed the possibility of Asian development models, coming out of the development experiences of East Asian nations, that challenge dominant global development norms. What does the possibility of an Asian development model mean to INGO practitioners in the U.S., Japan, and Cambodia?

Washington D.C.

In Washington D.C.'s development sector, the topic of an Asian development model arises in conversation rather infrequently. But, when it does, it is mostly to point to China as an example of how NOT to do development. The majority of China's aid is given in the form of loans, as opposed to grants, that finance natural-resource development (42 percent) or infrastructure projects (40 percent) (Wolf, Wang, and Warner 2013). In the U.S. development sector, Chinese aid is criticized for being self-serving, authoritarian, and putting nations in debt. Participants juxtapose this to the work of Western INGOs, which provide social services, build democracy and civil society, and should be understood as altruistic as compared with China's aid

regime. At a development workshop I attended in D.C., one panelist referenced what he called the "Asian Development model[34]" and expressed his concern it will be detrimental to the work that has been done to build democracy globally. Most participants shake their heads in agreement while a few contend that American practitioners need to know more about this Asian development model.

When asked directly about Japanese INGOs, donors, or any other East Asian development organization, no U.S. INGO employee that I interview in Washington D.C. or Cambodia had ever cooperated with a Japanese INGO. The majority are not aware that Japanese INGOs exist. However, many are aware, to some degree, of the work of JICA or KOICA (South Korea's bilateral agency), which are often discussed interchangeably in the U.S. Interviewees largely either disparaged the work of JICA compared to their own or simply remarked on its differences. One interviewee at a U.S. INGO, Justice International, inquires whether she is correct in her thinking that JICA programs are largely "safe" infrastructure, health, and education type projects. After I affirm that I believe this is a fair characterization, she replies, "Yeah, it's just safe… that just seems to be like the low hanging fruit whereas we do actual work."

A GFA interviewee explains to me that when she was a Peace Corps volunteer, she met several JICA and KOICA volunteers. She found them "sketchy," as they all worked within government ministries and seemed to be "funneling money or something." Thus, in the U.S. context, the foreign aid practices of China, Japan, and South Korea are largely dismissed or juxtaposed to the "real work" done by U.S. INGOs. However, as we will see below, there is much more engagement with the idea of an Asian Development Model in Tokyo and Cambodia.

Tokyo

In Tokyo, interviewees are acutely aware of the role of Japan vis-à-vis other Asian nations. Consistent with its status as an early developer, Japan was the first foreign aid donor in the East Asian region, providing aid to both China and South Korea.[35] In the Japanese development sector, practitioners want to promote Japan's prominence as Asia's first donor and cement its leadership in development and foreign aid in Asia. In comparison with their American

[34] Obviously, there are multiple Asian development models, arising from the development experience of different Asian nations. However, participants often lump them together and discuss the East Asian development model as if it is one thing. Therefore I do the same here, as I am analyzing the rhetoric around such a model rather than the specifics of these development models.

[35] In developing their own aid agendas, China and South Korea drew on some aspects of Japan's foreign aid model while rejecting others (Stallings and Kim 2017).

counterparts, Japanese practitioners are informed about foreign aid in South Korea and China, and consider these countries to be both competitors and allies in the creation and promotion of an Asian Development Model.

One INGO interviewee explained they believed KOICA was following the Japanese model, but just a few steps behind. In her description of KOICA, she notes that the Korean aid agency was originally more interested in "hard aid" and "infrastructure development." However, KOICA adjusted its model to follow Japan's soft aid style when it realized the importance of focusing on social development. She thinks that increasingly KOICA is following Japan's lead and, now, together, they can promote the social development of their "Asian neighbors." Japanese practitioners imagine an ideal world in which Asian nations develop together, with Japan at the helm.

There is also concern about competition with China and to a lesser extent, South Korea, in Japan's development sector. When discussing why Japan does not engage in civil society advocacy, one INGO interviewee states:

> Yeah… I think JICA, Japanese diplomat, even Japanese NGO staff…they remain neutral on Cambodia's democracy or other nations democracy… they want to show the good face of Japan because they really care about Chinese influence too much… they care a lot about the Chinese influence on Asia and the competition.

At a conference in Tokyo, there were several discussions about how Japanese aid might 'differentiate itself' from Chinese aid in Africa. One MOFA representative describes how Japan is trying to 'make a difference in African nations,' implying China is more self-interested in its engagement. He goes on to describe Japan as the 'only non-Western democratic nation, so Africa can learn together with us how to make a strong state." He strategically employs global rhetoric to pose Japan as an alternative to China and the West by valorizing it as the only democratic non-Western state providing aid in Africa. These claims are made despite the fact that programming that encourages democracy is rarely pursued by Japanese development organizations, and South Korea also provides aid in Africa.

Thus, in both Washington D.C. and Tokyo, the development work of East Asian nations is juxtaposed to make sense of one's own development imaginary and practices, and Chinese aid is often held up as an example of "bad aid." However, in Tokyo, we also see awareness of a regional vision of international development, in which Japan, China, and South Korea provide an alternative to Western models. This regional vision is also prominent in Cambodia.

Cambodia

Models of Asian development are particularly influential in Southeast Asia. Specifically, Japan, South Korea, and China's rapid economic development are seen as models to emulate in many Southeast Asian nations (Hoang, Cobb, and Lei 2017). Unraveling alongside Asian economic models are new cultural narratives about what makes a nation modern or developed. Studies of "inter-Asian referencing" note how the construct of the modern is being understood and pursued through an Asian lens in East and Southeast Asia, including the idea that development can be achieved without sacrificing "traditional" or "Asian" values, such as family loyalty (Chen 2010; Hoang, Cobb, and Lei 2017).

China, Japan, and South Korea are increasingly influential in Cambodia. Japan has a long history of promoting its influence in Cambodia. It played a key role supporting the Cambodian government after the Khmer Rouge, and a large percentage of Japan's foreign aid and media exports are directed towards the nation (Er 2013; Iwabuchi 2002; Stallings & Kim 2017). Cambodia is also a priority country for South Korean foreign aid, with grant and loan aid to the country increasing in recent years (OECD 2015). Additionally, South Korean popular culture is wildly popular among Cambodian youth (Heang 2016). Finally, in 2010, China surpassed Japan as Cambodia's top foreign donor, dispersing the majority of this aid through loans. In 2016, China owned approximately 45 percent of Cambodia's total foreign debt, figures that have only increased in the past few years (RFA 2018).

Alongside these changes, many Cambodians find compelling the notion that their country can develop by following an East Asian, as opposed to Western, development trajectory (Nam 2011). In Cambodia, and particularly in Phnom Penh, the vision of regional Asian development is noticeable in a number of ways. First, in general, young adult practitioners and their friends that I encounter in Phnom Penh typically spent a significant amount of time and money attempting to emulate an East Asian aesthetic. South Korean looks are the most commonly referenced beauty ideals but Japanese fashion is also popular. Young practitioners and their friends are oriented towards South Korean beauty ideals, often getting the haircuts of particular K pop stars, buying Korean skin lightening products, or shopping at stores carrying Korean and Japanese fashion. One INGO employee tells me, "Maybe twenty years ago people wanted to look like Americans, but now it's all about South Korea." Thus, East Asia, particularly South

Korea and to a lesser extent, Japan, serve as a model for young Cambodians to pursue a modern aesthetic.

In the development space, the growing power of East Asian nations in Cambodia as well as globally has a significant impact on the way that Khmer practitioners think about development possibilities and their nation. Cambodian practitioners in INGOs with donors from Japan and South Korea as well as Europe and the U.S. will juxtapose 'Western' and 'Asian' development models to one another. In 2010, when I first traveled to Cambodian and met NGO practitioners, I rarely heard this type of rhetoric, but it is now commonplace. Japanese INGO practitioners use the appeal of an Asian model to their advantage. HSA staff would often draw on ideas about the close relations or cultural match between Asian nations in discussions with state officials. State officials might be suspicious of NGOs and social movement building associated with Western NGOs, but practitioners could use narratives of Asian development to assuage such fears.

Khmer practitioners also contrasted Western and Asian development models in order to resist some aspect of an INGO's practices. At HSA, practitioners are annoyed that less money and time is invested in INGO staff than state officials. Thus, they exclaim that in "Western" INGOs practitioners are understood as valuable development actors, pointing to expensive staff retreats and trainings, and suggesting HSA follow this model. At GFA, staff are less aware of Japanese NGO practices, but they are familiar with the work of JICA and KOICA. At a staff meeting, GFA's director, Ranny is telling her program director, Tevy she cannot provide the government officials that attend her meetings with any per diem payments. Tevy is annoyed, inquiring how she's going to get them to attend without such payments. In doing so, she points out that JICA and KOICA provide such payments, and provide funding directly to the government, stating "Asians trust each other."

Such comparisons of Asian versus Western development models also took place on the topic of gender. During the week of International Women's Day, I attended a USAID workshop in Cambodia with two other Global Family Aid (GFA) staff members. For the workshop, high schoolers from all around Phnom Penh were asked to enter a video competition. Students created short films addressing gender-based violence prevention in Cambodia. At the workshop, the winning videos are shown, groups of high schoolers receive awards, and then, several panel discussions take place. These conversations focus on reasons why gender-based violence and violence against marginalized communities such as LGBTQ+ populations persists. The USAID

presider encourages the young people present to speak out against gender-based violence in their communities.

Workshop participants spent a significant amount of time considering the question, how does gender equality fits into 'traditional' Khmer culture? At the workshop, a teacher poses the question -- how can we strive for women's empowerment and preserve our culture?" One NGO director responds passionately, "what do you mean by culture?... if what you mean by culture is that we celebrate Khmer New Year, bring food to the monks, wear special clothes, then that's nice. But, culture is often used to oppress women. We are not destroying culture by women having more freedom. We need to have a dialogue about what is culture and how can women be part of it." Yet, a male practitioner from a different NGO responds defensively, "if we take up all these Western ideas about gender, how will we still be Cambodian?"

After the workshop, I wait outside for our GFA driver with a GFA staff member, Sophy. Sophy is now head of communication at GFA but prior to taking this position, she worked for the U.S. Embassy for over ten years. She is a fluent English speaker and well-versed in the ways that gender is discussed at USAID. Sophy explains that she, of course, thinks it is essential for women to work, make money, and be independent. Otherwise, "their husband can control them too much." In my time at GFA, I have seen Sophy encourage other female practitioners to talk to their husbands about household duties and the unequal division of labor. She is in her thirties, unmarried, independent, outspoken, and spends much of her time going out with her friends. Yet, she lives with her parents and always makes it home before ten every night so they don't worry. As we discuss the workshop's events and my comparative research, she tells me that she believes "the Japanese culture like the other Asian donors… is much closer to Cambodia's, you see…Americans are always trying to get women to speak out. I think the Japanese know you can make money, support your family, and maintain your values."

Yet, overhearing our conversation, a local NGO practitioner who had just attended the workshop disagrees; the Japanese "don't say anything about gender? Just as they don't say anything about the Cambodian elections?! How can they help make change in our country for women? Cambodian culture… there are many good things but there are many things that need to

change."[36] Sophy and this conference attendee are not the only practitioners to debate this topic after hearing about my work with HSA. Many practitioners in NGOs with donors from the U.S., Japan, Australia, and Europe, express similar perspectives, such as "Japanese culture is closer," "Japanese NGOs must better understand how to work with Khmer women," or "the Asian model is better for women." In contrast, other practitioners worry that challenging unequal gender norms will become more difficult with the rise of Asian donors. Nevertheless, in this discussion, we see the Asian versus Western models representing distinctive paths towards the development of gender norms in Cambodia.

New Imaginations of Development?

This dissertation illustrates two necessary considerations for a reconceptualization of how we understand 'global development norms' and the INGOs that disperse them. First, national variation due to nation of origin is produced as global norms are translated into programs and practices in developed nation contexts by donors and INGO headquarters. As we see in Chapter Two and Three, the U.S. and Japan interpret global norms very differently; practitioners from these countries, embedded in their nation's development imaginary, create specific INGO program activities to support. This is not a simple Asia versus the West difference, but more general as there is variation among Western nations as well. For instance, as discussed in Chapter Two, INGOs in the U.S. are more likely to define empowerment activities as promoting individual economic advancement while Scandinavian INGOs pursue empowerment activities that support collective mobilization (Wilks 2019). Studying each organization in an aid chain allows us to see how global norms are interpreted through the development imaginaries of specific nations within the global North and then, how distinct programs and practices articulate in recipient contexts. This allows for a full conceptualization of how the differences in program outcomes, INGO partnerships, and the organization of aid chains themselves are produced.

In closing, I return to the question introduced at the beginning of this chapter-- what does the possibility of an Asian development model mean for international development and INGOs? As illustrated above, it is possible that what practitioners call an Asian development model is arising to challenge the dominance of so-called "global" norms. Global norms are typically

[36] After the prime minister disbanded the opposition party, most Western donors discontinued support and spoke out against the 2018 election in Cambodia for not being free and fair. Japan did pull out of the election funding just days before it took place but remained publicly silent on why it did so.

deeply influenced by Western nations, particularly the U.S., given its role as a global leader during the second half of the twentieth century. Yet, we can see that the rhetoric around an Asian development model that provides an alternative path to an advanced society is influential in Cambodia as well as in Tokyo. I contend that my comparison of the development imaginaries of the U.S. and Japan demonstrates not only that national variation shapes INGO program outcomes and practices, but that contemporary notions of 'global norms' are, in fact, largely reflective of one development imaginary. This development imaginary, associated with the U.S. and other traditional Western donors, has long been dominant in the development sector but its hegemony may now be declining. As part of the larger geopolitical transformations discussed above, development practitioners in Cambodia and Tokyo are re-imagining what it means for a nation to advance and, in so doing, unmasking what has been presented as a singular, universal path as simply one route to development.

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Appendix 1

Donor/INGO Headquarter Data Code Sheet:

Code	**Sub-codes**
Gender	Program rhetoric
	Personal lives
Market	Rhetoric
	Management/ Professionalization practices
State	Donor state
	Recipient state
Civil Society	
Other global norms/rhetoric	Grassroots Advocacy
	Empowerment
	Sustainable Development Goals
	Universal Healthcare
Monitoring and evaluation	
Funding and grant-making	

Country Offices/Local Implementing Partners Data Code Sheet:

Code	**Sub-codes**
Gender	Program goal/rhetoric
	Organizational interactions
	Beneficiary interpretations
	Care work/emotional labor
NGO-State Cooperation	Goals
	Relationships
Cambodian State	Constraints
	Agency
Practitioner Identity	Modern professional
	Expertise
	Career goals
	Gendered beliefs
Global Norms	Grassroots Advocacy
	Empowerment
	Civil Society
	Sustainable Development Goals
	Universal Healthcare
Asian Regionalization	West v. Asia
Patronage	
Technology of Talk	