

A Critical History of Women's Health in Modern Sri Lanka

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A Critical History of Women's Health in Modern Sri Lanka

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A CRITICAL HISTORY OF WOMEN'S HEALTH IN MODERN SRI LANKA

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Abbreviations

ACWC	All Ceylon Women's Conference
AGA	Assistant Government Agent
BMI	body mass index
CML	Countway Medical Library
DTRU	Demographic Training and Research Unit
FDA	Food and Drug Administration
FHB	Family Health Bureau
FPA	Family Planning Association
FTZ	free trade zone
GDP	Gross Domestic Product
IBRD	International Bank for Reconstruction and Development
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IVF	In-vitro fertilisation
JVP	Janatha Vimukthi Peramuna (People's Liberation Movement)
LGBT	Lesbian, Gay, Bisexual and Transgender
LOC	The Library of Congress
LSSP	Lanka Samasamaja Party (Socialist Party of Sri Lanka)
LTTE	Liberation Tigers of Tamil Eelam

MCH	Maternal and Child Health
MDL	Mothers and Daughters of Lanka
MIT	Massachusetts Institute of Technology
MO/MCH	Medical Officer/Maternal and Child Health
MoH	Ministry of Health
MOH	Medical Officer of Health
NGO	non-governmental organisation
NPC	National Planning Committee
PA	Peoples' Alliance
PAA	Population Association of America
PHM	Public Health Midwife
PHNS	Public Health Nursing Sister
PIC	Population and Information Centre
PRH	Population and Reproductive Health
RG	Record Group
SAP	Structural Adjustment Policy
SIDA	Swedish International Development Cooperation Agency
SLFP	Sri Lanka Freedom Party
SPC	State Pharmaceutical Corporation of Sri Lanka
SVM	Seva Vanitha Movement
UNP	United National Party
USAID	United States Agency for International Development
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNRISD	United Nations Research Institute for Social Development
WHO	World Health Organization
WID	Women in Development
WWC	Well Woman Clinic

Chronology of Events

- 1948 – Ceylon gained independence from the British Empire. The first prime minister was D. S. Senanayake of the United National Party (UNP)
- 1953 – The Family Planning Association (FPA) of Ceylon was established by a group of elite women
- 1956 – Sri Lanka Freedom Party (SLFP) was formed by S. W. R. D. Bandaranaike, and he was elected the prime minister
- 1956 – Sinhala Only Act was introduced
- 1958 – The first major riots between Sinhalese and Tamils flared up in Colombo
- 1959 – Prime Minister S. W. R. D. Bandaranaike was assassinated
- 1960 – Mrs Bandaranaike took over as the first female prime minister, the first in the world
- 1961 – The pill clinical trials were conducted at the De Soysa Maternity Hospital in Colombo
- 1965 – Ministry of Health took family planning on board
- 1971 – First youth insurrection in Ceylon; also known as the *Janatha Vimukthi Peramuna* (JVP) uprising
- 1972 – Ceylon became Sri Lanka when it became a republic within the Commonwealth
- 1974 – The FPA launched the *Mithuri* programme
- 1977 – Sri Lanka opened its economy to capitalist market forces under J. R. Jayawardena of UNP. He amended the Constitution in 1978 and became the first Executive President of Sri Lanka.

- 1983 – Communal riots flared up and culminated in an ethnic war over the years
- 1987 – Second JVP uprising in the south
- 1989 – Ranasinghe Premadasa was elected the President of Sri Lanka
- 1993 – President Ranasinghe Premadasa was assassinated
- 1994 – Chandrika Bandaranaike Kumaranatunga was elected President of Sri Lanka under the SLFP
- 2005 – Mahinda Rajapaksa was elected as the President of Sri Lanka
- 2009 – Ethnic war ended under Mahinda Rajapakse's leadership

Acknowledgements

The seed of this book germinated when my body was ‘challenged’ by the Western medical practice of Sri Lanka. I was 29 when I gave birth to my second child—a daughter. I was well prepared for a normal delivery as my first was a Caesarean. When I was admitted to a private hospital in Colombo for the delivery, my regular gynaecologist was on leave during that long weekend due to *Thai Pongal*, so my care was taken over by another gynaecologist. When he asked me about my plan for delivery, he said, without giving me time to answer, ‘it is best to go for a Caesarean’. I mustered up some courage and told him that I preferred a normal delivery, but the gynaecologist refused to assist me for a normal delivery. He said it was too dangerous as the incision of the Caesarean delivery that took place three years ago might rupture when pushing. Then I agreed to Caesarean delivery. The following day, I heard from the nurses that the gynaecologist had been in a rush the previous day to ‘finish his cases’ as he had a personal engagement to attend in Kandy—a three-hour ride from Colombo. Was I a ‘case’ for him to ‘finish’ before his next appointment? Was that the reason he insisted that I go for a Caesarean? Whose body am I carrying? How did the gynaecologist take decisions about my body? From where did he get that authority? Who gave him that authority? Why cannot I decide the mode of this simple age-old practice—giving birth? Whose womb am I carrying in my body?

These were some of the questions that bothered me, but I did not have the time to explore them then. I am thankful today to the gynaecologist who made me go through a Caesarean section to give birth to my daughter for paving the way for my Ph.D. journey and subsequently to write this book.

I returned to these questions when I was following the MA programme in women's studies in 2006 at the Faculty of Graduate Studies at Colombo University. I was curious to know how women's health issues are handled at the government health sector, as my experience was limited to a private hospital setting. After being exposed to international conventions on reproductive health and rights through the MA programme, I became interested in studying the Well Woman Clinic (WWC) programme in Sri Lanka, which was introduced in 1996 to address women's health beyond reproduction. During my fieldwork, I observed the attention paid by public health midwives to meticulously recording all data on women's reproductive health, such as maternal mortality, contraception prevalence, and infant development and nutrition. As a historian, I do not perceive statistics as just numbers because these statistics contribute to creating knowledge about women's health in Sri Lanka. That knowledge helps Sri Lanka to maintain the image of 'success' in social development in South Asia. In this 'success story', 'women's health' serves as the linchpin to the attainment of Sri Lanka's national progress. Equipped with local knowledge, setting and international discourses on reproductive health and rights, I embarked on my Ph.D. in 2009 at the Centre for History of Medicine at the University of Warwick in the UK with two questions in mind: to find out what these statistics did not say about women's health, and to explore the role women's bodies play in women's health discourse in Sri Lanka. I explored these by engaging with the global discourses on development, population control, family planning, and reproductive health and rights.

This book is based on the research conducted for my Ph.D., and it presents a critical history of women's health in modern Sri Lanka. The Ph.D. research became possible due to the generous funding I received from the Wellcome Trust in the form of a three-year strategic award, and for the Wellcome Trust Grant (Grant No. 085434/Z/08/Z). Further, I received funds from the Royal Historical Award for Postgraduate Students and Cullum MacDonald Bursary, Graduate Programme in History, University of Warwick, UK, to conduct archival research at Countway Medical Library in Boston, Rockefeller Archives in New York, and Library of Congress in Washington D.C.

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not only for taking care of our children but also for having faith in me when I was losing confidence in myself. His unfailing confidence in my work, constant support and encouragement kept me going through some of the most challenging times; to my *putha* (son) Charitha for being understanding and hopeful of my work and to my *duwa* (daughter) Adithi for being ever so loving and caring. I am grateful to my amma (mother) who became a mother to my children during my long absences and my mother-in-law and father-in-law for being a strength and support to my family. My *akka*'s (elder sister) unfailing weekend Skype calls from Australia throughout my stay in the UK was a great relief for my homesickness. My sisters-in-law, Tharangi, Kamalini and Lakshi, and my ayya (elder brother) for supporting Rajith in many ways to take care of our children. I owe my nieces, Chamethya, Charanya, Chavinya, Tarani, Oneli and Shamaali and my only nephew Ramitha hugs and kisses for playing with and taking care of my children (their cousins) in their own special ways. I extend a big thank you to my maid, Kanthi, for taking care of the household work.

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and the librarian and officials at the Family Health Bureau for finding various 'lost' reports for me. I can never repay their friendship, generosity and kindness.

Introduction

Sri Lanka gained prominence in international policy circles as an apparent ‘success story’, first as a model colony in the early 1950s and later as a development model for South Asia by the 1970s. In naming Sri Lanka as a ‘success story’, experts pointed to the decreasing population growth rate and decreasing mortality. Renowned demographers attributed this to improvements in social indicators, such as high literacy rates, increased life expectancy and rise in female age at marriage. In this ‘success story’, women’s health serves as a linchpin in the attainment of national progress. But a focus on women’s health—as statistics and indicators—has also served to silence questions about Sri Lankan women’s broader experiences of their disaggregated health. In particular, while Sri Lankan ‘women’s health’ served the Sri Lankan state’s ‘success story’ well, what is less clear is how individual women’s bodies have fared within subsequent tellings of other twentieth-century Sri Lankan stories of late colonial, national, developmental, neoliberal and militarised phases.

This book studies this question through a critical examination of women’s health history in this island nation. It traces this history from its initial birth control, family planning (1953) stage to the development of population control, to militarisation and financialisation of women’s bodies, and ends with a critical examination of recent policies that claim to emancipate women’s health ‘beyond’ a myopic focus on their role as reproducers.

Although women’s health was vigilantly ‘controlled’ and ‘planned’ for the state-building project and women’s bodies were framed around the notion of social reproduction in the service of the nation-building project of post-independence Sri Lanka, women were neither subjects nor objects

of these two projects. Women's reproductive bodies were, rather, the ground for a complex and competing set of struggles around population, family planning, development, modernisation and ethno-nationalism in post-independence Sri Lanka. Further, the analysis of women's health/women's bodies helps to track the operation of power that serves to silence women's own corporeal subjectivity and to delimit the realms in which they can exercise their own agency.

What is critical history writing? According to Arthur Marwick, a historian's task is to produce new knowledge about the past.¹ How would a historian produce new knowledge since the past has already happened? Michel Foucault's suggestion of 'disturbing the tranquillity in which a particular knowledge of the past has been accepted' gives us an insight into producing new knowledge about the past.² In order to do that, the historian has to either find new sources or apply a critical lens or new analytical framework to the same sources. Based on statistics that were enumerated by public health midwives, women's health has been a 'success story' in Sri Lanka since the early 1980s. This is the 'accepted knowledge' put forward by development experts, demographers and economists, and it has become commonsense knowledge about women's health in Sri Lanka. I disturb the tranquillity of this statistical knowledge and interrogate it by bringing in women's corporeal experiences of health. While official indicators of 'women's health' had served the Sri Lankan state's 'success story' well, what is less clear is how women's individual bodies have fared within Sri Lanka's other historical moments in the twentieth century, such as during the late colonial, national, developmental, neoliberal and militarised periods. What emerges from this study is that women's health statistics have become so dominant in explaining this 'success' that they have managed to mask the processes that were muting and silencing women's bodies—both their individual and collective corporeal experiences.

In terms of sources, I have utilised a new lens to analyse the same sources as development experts, demographers and economists, and I have also used new sources. A critical lens was deployed by placing the same sources as the 'success story' along with the economic, development and ethnic politics of Sri Lanka. New sources such as communications between the inventor of birth control pills and the executor of the birth control pill trials in Sri Lanka were used to write a critical history of women's

health in modern Sri Lanka. As this is the first book on such a history in modern Sri Lanka, and it is situated at the intersection of a number of scholarly fields such as population studies, development studies, women's studies and the history of medicine, my aim is to capture the readership of undergraduates of the aforementioned disciplines. Thus, I take a narrative form of history writing by emphasising the interdisciplinary approach that I have taken in this research.

This book starts by explaining why and at what point Ceylon/Sri Lanka entered the global discourses on development, population control, family planning and reproductive health and rights.

CEYLON/SRI LANKA CARVING ITS SPACE IN THE GLOBAL TAPESTRY OF DEVELOPMENT

Since the 1970s, internationally renowned demographers, development economists and health experts have hailed Sri Lanka as a 'development model', based on low fertility and mortality levels, increasing life expectancy, commendable women's literacy rates and sound public health services.³ In heralding Sri Lanka's 'success story', experts pointed to the decrease in the country's population growth rate, from 3 per cent per annum in the late 1950s to 2.2 per cent by the late 1960s.⁴ Based on the mortality decline observed in 1954, Western demographers declared that Sri Lanka was 'only a generation behind' in attaining the development profile held by economically advanced countries. This was particularly notable given the same development experts' judgement of Sri Lanka's regional neighbours: India was 'three generations behind' while Pakistan and Burma were deemed to lag two centuries behind the West.⁵

Sri Lanka's rapid progress towards political modernity was understood to be in part the result of its educational infrastructure—an infrastructure that served both boys and girls. Not only Sri Lankan men but also elite Sri Lankan women were politically active in gaining their franchise. The Women's Franchise Union was formed in 1927 by a group of professional women—many of them were wives of nationalist and labour party leaders. Among the pioneering women of the franchise movement were doctors, teachers and lawyers. This was possible in part because Baptist and Methodist missionaries from the American Mission and the Church

Missionary Society established schools for Sri Lankan girls from the 1820s. Local languages (Sinhalese and Tamil) were the medium of instruction in schools for the poor and English for the economically privileged.⁶ The Ceylon Medical College was inaugurated in 1870 in Colombo, and the first female student was admitted in 1892. The English Training College for teachers was opened in 1902 and women were admitted for the first time in 1908.⁷

These achievements of civil society were possible not only because of the state's welfare policy in education but also because of its health policy. By the 1950s, Sri Lanka had become the template to be followed by other nations of the region to develop their public health care systems.⁸ Western demographers became interested in Sri Lanka in the 1950s because Sri Lanka was able to successfully bring down its mortality rates. According to one economist/development expert, the mortality rate was brought down to 66.1 per 100,000 population in 1947 from 187.3 in 1946 due to the efficient anti-malaria campaign launched in Sri Lanka in 1946.⁹ Observing the health care system in Sri Lanka, Myrdal said:

[o]f the countries with the greatest health problems and the highest mortality in South Asia, and in the world, India has achieved remarkable results in public health work since 1950. Indeed, India's achievements suggest that, with time and effort, these countries too could duplicate the experience of Ceylon.¹⁰

Myrdal believed that the diligent efforts in public health by the colonial administration and later by the post-colonial state have shown progressive results in Sri Lanka, which could be used as a template for South Asia. In turn, renowned demographers attributed these demographic improvements to pre-existing social indicators, such as high literacy rates, rise in female age at marriage and increased life expectancy at birth. The female literacy rate rose from 44 per cent in 1946 to 67.3 per cent in 1963 and 83.2 per cent in 1981.¹¹ Noting the rise in female age at marriage, J. C. Caldwell et al. say that 'by the mid-1970s Sri Lankan women were marrying not at puberty, but a decade after'.¹² Life expectancy at birth rose from 60 in 1960 to 67 in 1980.¹³

AIM OF THE BOOK

The term ‘woman’s body’ or ‘discourses on woman’s body’ in this book denotes a particular ideology framed through nationalist discourses in colonial Sri Lanka. It is part of a broader project where a woman’s body was disciplined and its margins of revelation were demarcated in colonial Sri Lanka. This particular ideology has influenced, and continues to influence, women’s perception of their bodies and reproduction (both biological and social). The concept of ‘woman’s body’ will be addressed at length below—both in general and in terms of its specific relationship to and relevance for the Sri Lankan case. This book seeks, then, to situate both the ‘women’s health’ discourse and ‘discourses on a woman’s body’ within a unified analytical framework with the aim of writing a critical history of women’s health in modern Sri Lanka.

This book also analyses the women’s health ‘success story’ through a critical analysis of the history of women’s health policy and practice in modern Sri Lanka—from population control to family planning to reproductive health and rights (from 1953 to 1996). Instead of considering this ‘success story’ through demographic or development discourses, I read women’s health and population policy documents ‘against the grain’, drawing attention to issues of women’s health and women’s bodies that demographers, family planners, development experts, economists and policymakers of Sri Lanka have so far refused to recognise and conveniently and consistently ignored. They had carefully constructed this ‘success story’ by treating women’s health as a purely statistical indicator, disregarding the essentiality of the corporeal experiences of women when implementing women’s health policies such as population control and family planning. In saying this, I do not disregard the efforts made by public health officials in achieving commendable standards in maternal health. Saving the lives of mothers and infants through skilled care at childbirth and having small families through effective family planning programmes have a positive effect on women’s corporeal experiences. These efforts were emphasised in official reports and have become commonsense knowledge already. Thus, by writing a critical history of women’s health in modern Sri Lanka, I attempt to disturb the tranquillity with which this commonsense knowledge is being produced and accepted. This is neither a history of

the Family Planning Association (FPA) of Sri Lanka nor a demographic history.¹⁴ Instead, it is an analysis of how the state deployed women's health in post-colonial state-building and nation-building projects of Sri Lanka. As mentioned above, this study is situated at the intersection of a number of scholarly fields, including population studies, development studies, women's studies and the history of medicine. This study both frames a discursive institutional history of women's health in Sri Lanka and suggests a new set of material and discursive categories for the writing of modern Sri Lanka's new critical histories.

Considering how central the discourses on women's bodies are to most of the aforementioned scholarly work on Sri Lanka, it is surprising that they have not been critically investigated before. Perhaps this indicates the success of the women's health discourse in becoming 'commonsense' when it comes to understanding women and modernity in contemporary Sri Lanka. In light of this, the main objective of this research is to highlight the danger that lies in a tranquil acceptance of the women's health 'success story' as 'commonsense' knowledge today. By doing so, I unravel how politics of population control, family planning, development, nationalism and the neoliberal market have both produced and have been produced by the women's health programme of modern Sri Lanka.

Further, this book addresses two distinctive and rather broad objectives. First, it traces the history of the women's health discourse by paying attention to those historical moments where women's bodies were mobilised, but not emancipated. By pointing out the discursive and policy disconnect between women's health and discourses on the woman's body in Sri Lanka, this project provides a new approach to the study of women's health and women's history in modern Sri Lanka.

The other objective of this book is to interrogate the paradigm shift—'beyond reproduction'—that lies at the heart of the contemporary women's health discourse. In the wake of the International Conference on Population and Development (ICPD) held in Cairo in 1994, which attempted to critique approaches to women's health restricted to reproduction, a new paradigm emerged, termed 'beyond reproduction'. What this term would mean in health policy and practice was less clear. In the Sri Lankan context, 'beyond reproduction' presented an apparent about-turn in approaches to women's health, as the new concept disturbed

the orthodox view that women's health was necessarily reproductive health. In Sri Lanka, the shift manifested in the launch of a Well Woman Clinic (WWC) programme in 1996 that focused on the early detection and treatment of non-communicable diseases such as cervical cancer and breast cancer. By interrogating the concept of women's health 'beyond reproduction', my attempt is to understand why it has proved so difficult in Sri Lanka to disentangle women's health from the Malthusian ideology of 'controlling and planning', and women's bodies from biological and social reproduction.

There are two broad themes that run through the book. One is the historiography of development, modernisation and women's health. The other is the discourses on the woman's body—global and local. These two themes are vital to writing a critical history of women's health in modern Sri Lanka.

HISTORIOGRAPHY OF DEVELOPMENT, MODERNISATION AND WOMEN'S HEALTH

At the global level, the development 'success story' of Sri Lanka is understood as a by-product of the development and modernisation projects put forward by American economists and demographers in the post-World War II era. American economic historian W. W. Rostow explained his thesis in *The Stages of Economic Growth: A Non-Communist Manifesto*, in 1960. This was published at the historical moment when the field of 'development' was taking shape. According to Rostow, economic development or modernisation is the final destination of development, which is marked by mass consumption. This is the path he prescribed for countries to follow in order to overcome the chaos created by World War II. His seminal work primarily conveys two messages about US defence and foreign policies: first, that the US should assist other countries in their development projects in order to perpetuate capitalism; and second, the US should concentrate on containing the spread of communism, especially in the newly independent states of Africa and Asia. Due to his academic and political affiliations during the 1950s and the 1960s, this hypothesis had an enduring influence on a whole generation of economic and development planners.¹⁵

According to Rostow's economic growth theory, population growth was seen as coterminous with poverty, destitution, a traditional society, underdevelopment and pro-communism. Thus, US policymakers sought the assistance of demographers to formulate a population control policy to develop the underdeveloped world. Hodgson points out that in this endeavour, a generation of demographers shifted from a social science perspective to a policy-oriented one in the 1940s and 1950s.¹⁶ Frank Notestein and Kingsley Davis, professors in the Office of Population Research at the University of Princeton, were the two most influential demographers engaged in the formulation of population control policies. Together, they developed the modern demographic transition theory in 1945 and, according to many, this provided the much-needed justification for development policymakers to curb population growth in the Third World.¹⁷ Notestein and Davis' modern demographic transition theory appeared as a 'social engineering' project, placing 'all countries on a grand evolutionary scheme running from pre-transitional ("traditional") to transitional to post-transitional ("modern")'.¹⁸ Rostow's economic growth theory also placed the countries in an evolutionary scheme running through five stages of growth.¹⁹ By sharing the same set of assumptions, the logical end point of both these theories inevitably became capitalism. Further, both theories perceived population growth as an indication of a traditional society or initial stage of the evolutionary scheme towards development. In other words, the modern demographic transition theory supported Rostow's growth theory.

Both these theories together became a unique explanatory model to develop the backward, non-industrialised societies of the Third World. According to this model, it was imperative to control and plan the traditional populations of the Third World in order to develop and modernise these countries. Controlling and planning the population was new to traditional societies in the 1950s. Thus, it became imperative for the First World to intervene in the population planning of the Third World in order to maintain their capitalist economies to rebuild post-World War II Europe. A budget allocation to fund population control programmes in the Third World became a foreign policy decision in the Western countries in order to maintain their status quo. The Rockefeller Foundation and the Ford Foundation in the US and the Swedish International Development

Cooperation Agency (Sida) were the pioneers in funding population programmes of the Third World.²⁰ James Scott's concept of 'legibility' is useful here to understand how Sri Lanka entered the modernisation discourse through these interventions of social engineering.

In his critique of the modernisation project, Scott explains that it is imperative for modern states to make traditional societies 'legible' in order to effectively carry out the intervention programmes of a social engineering nature in the Third World.²¹ Identifying 'legibility' as the main distinction between pre-modern and modern states, he contends that the pre-modern state (or traditional societies) was partially blind because

it knew precious little about its subjects, their wealth, their landholdings and yields, their location, their very identity. It lacked anything like a detailed 'map' of its terrain and its people. It lacked, for the most part, a measure, a metric, that would allow it to 'translate' what it knew into a common standard necessary for a synoptic view.²²

According to Scott's definition, by the late nineteenth century, colonies of the British Empire (including Sri Lanka) had entered the modernisation discourse through census enumeration. In 1871, the British colonial administration carried out the first island-wide census of Sri Lanka. This helped the Empire to translate the knowledge about the subject societies into a 'standard synoptic view'. The Empire made its colonies 'legible' enough to extract taxes and carry out infrastructural development—transportation, communication, education and health—necessary for an uninterrupted supply of raw materials and markets of the imperial regime.

This 'legibility' was the ground on which demographers and economists understood and designed population policies in the post-World War II era with the aim of organising the world. Through these programmes, women's reproductive bodies became legible to international organisations. Due to this 'legibility', funding agencies of the First World were able to design, fund, evaluate and monitor women's health programmes in the Third World.

Influenced by the global population discourse, a non-governmental organisation—the FPA of Ceylon—introduced population control and family planning programmes in Sri Lanka as a welfare measure in the

early 1950s. Local policymakers, economists and family planners diligently carried out these programmes, which helped Sri Lanka to become a development 'success story' in the region.

Fuelling the 'controlling and planning' approach, women's health scholarship in Sri Lanka focuses more on issues related to reproduction, such as the emotional disorders of women during their reproductive age, effects of antenatal body mass index (BMI) on pregnancy and its outcome, women's reluctance to go for hospital deliveries, women's attitudes regarding contraceptive methods and evaluation of the safe motherhood initiative.²³ An overemphasis on reproduction is clearly manifested in these issues. These studies have been conducted using mainly quantitative surveys with the intention of improving maternal health care and reducing infant mortality rates.²⁴ They aim to look at women's health—mainly their ability to reproduce—within the population-development framework in order to develop the country as advocated by the West for more than five decades.

Furthermore, the disciplines that engaged with issues of women's health, such as health economics, medical sociology and community medicine, focus more on local issues in small communities rather than questioning the public health system, the welfare state and the neoliberal market forces that have a profound impact on health as a basic right of women in Sri Lanka.²⁵ Women's bodies, women's experiences and women's *métis* about their bodies have not come up as categories and have rarely been problematised in medical and health research in Sri Lanka.²⁶ The myopic nature of medical and health scholarship in Sri Lanka is not helpful in addressing my question about the women's health 'success story'. In the demographic and development approach, women's health is treated as numbers in state statistics, reflecting the country's performance within the linear prescribed progress towards development. Modernity, development and family planning became commonsense terms in the 1950s, and questioning their 'fundamental truth' appeared totally irresponsible and irrelevant. However, my approach to writing a critical history of women's health goes beyond statistics. It is the sum total of the discourses on women's bodies, women's corporeal experiences and their feelings towards motherhood and having a family.

DEBATES ON THE WOMAN'S BODY: GLOBAL TO THE LOCAL

Theorists working on the body acknowledge the influence of feminism as a political movement on the emergence of the body as a scholarly theme.²⁷ Feminists brought the body to the forefront in their analysis of power relations under patriarchy. The woman's body is a widely interrogated and analysed concept in the medical sciences (medical anthropology, sociology of health and clinical studies) and studies on population, development, nationalism, colonialism, modernisation and gender/women's studies. Each of these disciplines takes an interest in women's bodies because of their biological, social, economic, political and national significance. I will draw on some of these debates in my investigation into the woman's body in Sri Lanka.

Within medical sciences, the woman's body is studied as a biological reproductive body. Studies have discussed the making of the natural, women-centred event of childbirth into a male-dominated medical issue—treating pregnancy as a disease and issues on menstruation—with the development of gynaecology.²⁸ Oakley points out that by the mid-1950s, pregnancy had become a fully medicalised condition.²⁹ Beginning with the ground-breaking *Your Bodies, Our Selves* (the Boston Women's Health Book Collective, 1971), women's health occupied a central place in the feminist research agenda. Citing a number of scholars, Davis argues that medical discourse has played an important role in constructing the female body as unstable, deficient, diseased and unruly by nature.³⁰ According to the mind–body dualism in Cartesian thought, the female body represents nature, emotionality, irrationality and sensuality. And it always represents the 'other' mysterious, unruly being that 'needed to be tamed and controlled by the (dis)embodied objective male scientist'.³¹

Although Foucault did not analyse women's bodies per se, his identification of the body and sexuality as the direct locus of social control stimulated extensive feminist interest. Foucault identified medicine as a regulatory mechanism which gained ascendancy over other forms of knowledge. He asserted that disciplinary practices adopted by medical clinics objectified bodies (both individual and population) and created productive and docile bodies. When medical knowledge about the woman's

body emerged as scientific knowledge, medical clinics became a place of surveillance where the woman's body was effectively regulated, monitored and disciplined. Further, Foucault's concepts such as 'discipline', 'docility', 'normalisation' and 'biopower' were widely studied and developed by feminists of the 1980s with regard to women's bodies.³² When applying these Foucauldian concepts to Sri Lanka, we need to be cautious about other social factors such as ethnicity, class and caste that play a significant role in deciding the status of women in society. Then again, due to free education, social mobility was possible and women entered the professions of teaching and medicine as early as the late nineteenth century and early twentieth century, respectively. Thus, women in Ceylon/Sri Lanka exercised agency to a greater extent when compared with women in the larger region.³³

Rejecting the traditional dualistic understanding of power—the ruler and the ruled, the oppressor and the oppressed—Foucault perceived power as a discipline that is constantly exercised through means of surveillance. Feminists such as Sandra Bartky and Susan Bordo developed the concepts of 'self-policing' and 'self-surveillance' through their studies on disciplinary practices such as dieting, exercise and beauty regimens, and eating disorders.³⁴ Bartky argues that these disciplinary practices subjugate women by generating skills and competencies that depend on the maintenance of a stereotypical form of feminine identity, making them 'self-policing subjects'.³⁵ Developing this idea, Bordo argues that for these 'self-policing subjects', subjectivity is maintained not through physical restraint but through individual 'self-surveillance and self-correction' in accordance to norms.³⁶ It is not only the medical clinic but also society in general which works as a policing mechanism vis-à-vis women's bodies.

When analysing family planning initiatives carried out especially in the 1980s, we could see questions on population density and resources in school mathematics textbooks. Textbooks act as a conduit to inculcate a particular ideology in young minds. By incorporating such mathematical questions, the state was able to cultivate a fear about population growth. This led to the creation of Bordo's 'self-policing subjects' in Sri Lanka. Thus, *Punchi Pavula Raththaran* (small family is golden) was the slogan that was widely displayed in the 1980s on large billboards erected in towns.

Within demographic studies, the woman's body is studied as a procreative body capable of influencing the population growth rate of a country. By calculating fertility rates, demographers are interested in a woman's body for the impact it could have on setting the fertility trends in a country. Development experts perceive the woman's body as a 'reproductive machine', reproducing a future labour force. By using the term 'labour' to denote workers as well as the pain that a woman goes through when giving birth to a child, Emily Martin argues that medical terms join forces with capitalism to create a hegemonic understanding of women's bodies as machines that will produce the future labour force.³⁷ Foucault's concept of 'biopower' succinctly places all the aforementioned ideas neatly into a package within a liberal, democratic, capitalist society. Foucault coined the term 'biopower' to denote

a new form of power that emerged in the eighteenth and nineteenth centuries (along with liberalism, democracy and capitalism) through which the state both regularises populations and disciplines individual bodies. Foucault argues that biopower comes into being as the state begins using new technologies and discourses of health, birth, mortality, and demography as mechanisms of regulatory power to exercise control over populations.³⁸

Further, Foucault saw biopower as an indispensable element in the development of capitalism because he argued that capitalism would not have been possible without the controlled insertion of bodies (population) into the machinery of production (economic processes).³⁹ In fact, his concept of biopower talks about a new political right of the capitalist state: 'the power to "make" live and "let" die', that is, the state's ability to regulate, control and protect populations who are fit to work (productive labour force) by marginalising bodies that are inferior, deviant and threatening.⁴⁰

A woman's body became a political issue as feminists started to interrogate, analyse and deploy issues on reproductive rights, contraception, abortion rights, sterilisation, domestic violence, mothering theories and reproductive technologies of In-vitro Fertilisation (IVF).⁴¹ This trend has made the language of 'owning' or 'controlling' one's body commonplace within feminist rhetoric.

Scholars studying colonial societies have pointed out that disciplining or making the colonial body industrious was intrinsically linked to the

introduction of Christianity.⁴² Researchers studying Western medicine in colonial settings have come up with three major arguments—Western medicine was a tool of imperialism, Western medicine served the imperial state as an agent to control the oppressed populations and Western medicine's role was to legitimise imperial rule through benevolent projects such as setting up of hospitals, clinics and dispensaries.⁴³

Analysing independence movements and nationalist movements in South Asia, feminists have shown how the state deployed women's bodies to foster a national identity among its people, and also to maintain its position as a patriarchal father figure.⁴⁴ In her insightful analysis of the recovery process of abducted women of India and Pakistan after Partition in 1947, Ritu Menon pointed out that the state's responsibility towards its citizens was embedded in discourses of nationalism, honour and manhood.⁴⁵

The common theme that runs through all these studies and disciplines is that women's bodies are deployed (across space and time) and disciplined, in one way or another, to service the family, the economy, the nation and the state. Consequently, much of feminist research has concluded that women are deprived of autonomy and rights over their bodies. Regulation of reproductive practices has become a form of social surveillance today. These larger debates on women's bodies at the global level have definitely influenced scholarship on the woman's body in Sri Lanka.

Studies on Sri Lankan women's sexuality and their maternal, social and cultural reproductive bodies have been done by eminent scholars from the 1990s.⁴⁶ Women's health did not emerge as a category of analysis in any of these works. A related body of work has investigated the relationship between the maternal body and the militarised body in relation to issues of nation-building and ethnicity, where they were forced to depart from traditional attire and behaviour and adopt completely different, untraditional roles.⁴⁷ These studies asked: What is this so-called traditional role and how was it constructed for a particularly Sri Lankan context?

This book concentrates on Sinhalese Buddhist nationalism, which took shape in the late nineteenth century, in order to map how the woman's body became a marker of identity in the nationalist project of colonial and post-colonial Sri Lanka. Although Tamil and Muslim nationalist projects also framed the woman's body in particular ways at different moments in history, in this book I do not deal with the Tamil and Muslim trajectories

in detail. This is because Sinhalese Buddhist nationalism is the dominant discourse in the state-building and nation-building of post-independence Sri Lanka. The tensions between dominant and minority nationalist discourses are apparent in the way family planning programmes were implemented, but this book does not take an intersectional approach in theorising other corporeal experiences of women.

The initial nationalist ideology (which was heavily influenced by India) in the late 1800s was a reaction to British colonial power: trying to define or 'imagine' what is Ceylonese in relation to the ruling power. It was a moment of defining Ceylonese for Ceylon. Within this discourse, women's position and role in the Sinhalese Buddhist nationalist discourse was defined mainly by Anagarika Dharmapala, one of the leading nationalists of the day, and was also heavily influenced by the Theosophical Society during the colonial period in the late 1800s.⁴⁸ Dharmapala had a great impact on the lives of the rising Sinhalese middle class in the early twentieth century. The adoption of Western manners, etiquette and dress by the new middle class was severely criticised by Dharmapala, who introduced a new Sinhalese lifestyle in which he bestowed women with a special and rather active role within the domestic sphere. He published a pamphlet, the *Daily Code for the Laity* (*Gihi Dinacharyawa*) in Sinhala, in 1891 as an attempt to 'civilise' the emerging Sinhalese middle class in the hope of gearing them to take up the modern nation-state building project.⁴⁹

In the *Daily Code for the Laity*, women were advised to maintain a clean, orderly house and to attend to all housekeeping and child-rearing duties. The middle-class mother was endowed with holy status within Buddhist revivalist ideology—she was proclaimed the 'Buddha at home' (*Gedara Budun*). Through this newly bestowed respect, her body and sexuality became carefully disciplined and was made docile in order to fulfil the social reproductive role of bringing up moral and cultured children who would be the future of Mother Lanka.⁵⁰

Despite being dated, Dharmapala's concepts, such as 'Gedara Budun', are still taught in the school curriculum of Sri Lanka. Even though the female literacy rate in Sri Lanka is a commendable 97 per cent today,⁵¹ as Kumari Jayawardena⁵² pointed out, women are still educated within an ideological framework of patriarchy. Then what do these excellent female literacy statistics obfuscate? Since women's education is more geared towards

producing good housewives, to fulfil a necessarily social reproductive role, education does not equip women with the essential tools to think ‘beyond’ this social reproductive role that they are traditionally bestowed with. In fact, female education in Sri Lanka has become a double-edged sword. On the one hand, the female literacy rate is high when compared to other countries of the region, which is the most crucial determinant to measure women’s empowerment. On the other hand, women’s education has a strong emphasis on social reproduction. The empowerment that women are supposed to achieve through education is entangled with the aim of training for social reproduction, thus depriving women of reproductive rights. This problem lies at the root of my interrogation of the women’s health ‘success story’ of Sri Lanka.

Radhika Coomaraswamy, Neloufer de Mel and Adele Balasingham have explored a new category of women during the Sri Lankan ethnic conflict—the Liberation Tigers of Tamil Eelam (LTTE) women cadre and their role.⁵³

Another set of scholars, Selvi Thiruchandran (1999), Sepali Kottegoda (2004), Caitrin Lynch (2007) and Sandya Hewamanne (2008), has attempted to understand the new categories of womanhood that emerged with the opening up of the economy in 1977 and the ethnic conflict of 1983.⁵⁴ The new categories include female factory workers in free trade zones (FTZs), female migrant domestic workers in the Gulf and female-headed households due to Sri Lanka’s protracted ethnic conflict. Most recently, Mythri Jegathesan has explored the desires of contemporary plantation workers and their efforts to pursue social and economic dignity.⁵⁵ Despite the centrality of women’s bodies and sexuality—and, by extension, their health—to these topics, women’s health appeared rarely, if at all, as a subject of analysis in the works of these scholars.

From the discussion above, it is clear that the ‘women’s health’ discourse in Sri Lanka is predominantly a territory confined to health policymakers, medical professionals, demographers and economists, while discourses on the ‘woman’s body’ seem to be a territory largely confined to the attentions of feminist social scientists. Thus, the aforementioned studies are not as helpful as I had hoped in critically addressing my question about Sri Lanka’s women’s health ‘success story’. Very few have dared to trespass upon the epistemic and disciplinary boundaries between discourses on

‘women’s health’ and the ‘woman’s body’. Broadly speaking, ‘woman’s body’ is a subjugated discourse within the women’s health discourse of modern Sri Lanka. As women’s health indicators were crucial in building up the ‘success story’, discourses on the woman’s body and its role in women’s health were neglected. Because of this subjugation, women are essentially denied the right to their bodies in the women’s health discourse of modern Sri Lanka. By subjugation, I do not mean that women are forcefully denied the right to their bodies, but that the woman’s body is neatly packaged into a form of social surveillance in the modern welfare state of Sri Lanka. This surveillance is essentially a product of twentieth-century global discourses on population control, development and modernity, which I have already discussed above. Like other Third World countries, Sri Lanka could not escape this surveillance process.

TRESPASSING EPISTEMIC AND DISCIPLINARY BOUNDARIES

When writing a critical history, one cannot remain confined to traditional boundaries. Either disciplinary boundaries have to be expanded or existing disciplinary boundaries have to be crossed. I had to transgress disciplinary boundaries in order to explore the silences and muted voices on women’s bodies that women’s health statistics failed to express.

By transgressing disciplinary boundaries and trespassing into an unknown epistemic province of public health policy-making and public health practices, I was able to challenge the women’s health success story. Women’s health and women’s health discourse have come to denote institutions, statistics and state-building, while research on women’s bodies and discourse on the woman’s body deal with culture, religion and nation-building. I engaged in archival research and the critical reading of published sources to deal with the institutional women’s health component of the research. Conducting research at a number of archives, both in the First and the Third Worlds, taught me the way to cope with different systems with patience. The highly systematic and organised archives of the US and the UK provided all the material that I looked for within a considerably shorter time period. The FPA resource centre, which was subjected to floods twice between 2000 and 2010, also managed to retrieve

the material that I wanted through personal contacts of the director of the resource centre.⁵⁶ I was also given access to the Population and Information Centre (PIC) library, which has been closed since 2009 due to a lack of funds, purely because the librarian of the PIC and Family Health Bureau (FHB) are friends and identified me as a diligent researcher. I find this personal touch at efficiency rather fascinating, despite the context of the lack of a proper institutional framework in these Third World libraries and resource centres.

The woman's body component was mainly dealt with by conducting in-depth interviews. As I conducted my archival work and fieldwork at a number of different geographical sites, I did so in a contrapuntal manner. That is, I spent the first three months reading documents at various archives and libraries, and then the next three months engaging in fieldwork, conducting interviews. The change in field sites gave me space not only to contemplate and interrogate new categories and issues, but also made me realise how I trespassed into the epistemic provinces of the sociologist and the anthropologist. To access these research materials, I assumed different roles according to the setting.

The research process was a challenging experience, particularly when I had to face medical professionals and demographers of Sri Lanka who challenged my methodology, shocked that a historian might dare to probe into their 'scientific episteme'.⁵⁷ Even though women's health is centred around issues concerning the population growth rate for the medical professionals and demographers of Sri Lanka, for me (a historian), women's health extended beyond reproduction to reproductive health and rights, discourses on the woman's body and women's corporeal experiences. That is why I could not limit my research to the traditional site of the historian—the archives. I had to conduct interviews (oral history interviews and in-depth interviews) with people from different strata of society.⁵⁸ This seemed quite an unusual practice for a historian to many of my interviewees, especially when the history of medicine is not an established discipline in Sri Lanka.⁵⁹ Medical doctors such as Christopher Gunapala Urugoda and medical sociologists such as Kalinga Tudor Silva have documented the history of certain medical and health practices in Ceylon.⁶⁰

POSITIONING MYSELF AND ETHICS

When doing research at a number of research sites and geographies, I realised that I had to assume different identities and positions suited to the situation. Anthropologists have widely debated about the researcher's position—subjective insider and the objective outsider—that he/she has to acquire during data gathering.⁶¹ I draw from their works to understand my position as a researcher.

Throughout my research I remained self-conscious and carried on a self-critique. By doing so, I acquired multidimensional identities. Similar to Visweswaran's argument, I also had to choose different identities according to the nature of the situation I found myself in.⁶² By having multiple identities, I did not commit any dishonesty. My approach to adopting multiple identities can be summed up by the Sinhala proverb: '*théne hatiyata ane gahanawa*' ('to hit the nail according to the place', implying to act according to the situation).

As mentioned above, my methodology comprised of both archival and field research. While conducting oral history interviews and in-depth interviews with people from different social strata, I used pseudonyms to protect the identity of those respondents who are beneficiaries of the public health sector.

The interviews that I carried out can be categorised mainly into two sub-groups. The first category can be identified as women's health policymakers. I have conducted interviews with retired policymakers, implementers of the population policy, members of staff at the Medical Faculty of the University of Colombo and retired women teachers of public schools. I tapped into their memories through oral history interviews because I was keen to know how population policy measures and their implementation were conceptualised in Sri Lanka, especially in the 1970s and 1980s. Agreeing with Alessandro Portelli, I used oral histories to speak about the 'meaning of the event' and not 'about the event', because it reveals unknown aspects of a known event.⁶³ These interviews supplemented and at times elaborated my archival findings. Living memories were also helpful to understand the 'controlling and planning' mind-set of health policymakers and bureaucrats of Sri Lanka, and the 'cult of population control' embedded in the official rhetoric of women's health in Sri Lanka.⁶⁴

The second category of informants can be identified as recipients of the women's health policy. Considering how the state deployed women's bodies in implementing population policy measures in Sri Lanka, I conducted in-depth interviews with five FTZ workers, five housemaids returned from the Middle East and 10 WWC attendees at the most-attended WWC in Sri Lanka. All these groups of women bear a distinct relationship to my research. The FTZ workers and migrant housemaids were a product of the open market economy that Sri Lanka adopted in the late 1970s. Both FTZ workers and migrant women occupy a distinct and privileged status within contemporary state policies and the social milieu of Sri Lanka.⁶⁵ Even though these women are marginal in the body politic, they are central to the national economy. Given the importance of their labour, the state takes measures to monitor their reproductive bodies, *but not their health*. Through conducting in-depth interviews with these women, I explored how the state mobilised discourses of 'patriarchy' and 'motherhood' to discipline women's reproductive bodies. By doing so, the state continued to frame women's bodies within the social reproductive role as docile girls in the FTZs and responsible mothers in the Gulf.

The in-depth interviews with WWC attendees address a slightly different issue in my research. They helped me explore how the shift from family planning to reproductive health and rights advocated by the ICPD in 1994 was translated at the grassroots level through the WWC programme—the consequence of the new discursive formation of 'beyond reproduction'.

The only difficulty I faced during my interviews with WWC attendees was their constant reference to me as 'doctor'. Since they are used to doctors interviewing them for various researches, they found it hard to remember that I am not a medically trained person. Further, they started asking for treatment for various ailments, so I had to remind them that I am not a medical doctor but a historian. In fact, they were initially bemused at a historian's interest in the woman's body, because they saw bodies as a territory confined to the interests of medical personnel.

LIMITATIONS OF THE RESEARCH

Time is a deciding factor in conducting research. It is not possible to complete research without facing a number of limitations. These

limitations are mostly due to not having enough time to engage with the sub-stories that we encounter in the long and arduous research journey. Mine was no exception.

The biggest limitation that I encountered in my research was not being able to represent or bring out other minority ethnic ideologies (Tamil, Muslim and Burgher) concerning women's health and bodies. I have only concentrated on the Sinhalese Buddhist ideology, which is generally the hegemonic ideology of the state. Even though Sri Lanka is comprised of a heterogeneous community, it claims to be a Sinhalese Buddhist state with 2,500 years of written history. Due to time constraints as well as the fact that I am unfamiliar with the languages of these communities, I had to limit my research to the Sinhalese Buddhist ideology of the state. However, I do not mean to imply that the stories of minority groups are insignificant when attempting to write a comprehensive history of women's health in post-independence Sri Lanka. In fact, these minority stories are 'subjugated stories' in the grand narrative of women's health in Sri Lanka.

BOOK PLAN

Chapter 1 explores the evolution of the women's health discourse in state strategy that worked towards cementing Sri Lanka's special status as a development 'success' story. In particular, the chapter investigates how international and local demographers wove Sri Lanka into a broader narrative about poverty, population, women's health and development across the globe. Through a careful reading of the works of demographers, I trace how Sri Lanka made its mark on the demographic map of the world as an 'interesting case study' in the 1950s, becoming a 'development model' for South Asia in the 1970s, and the survival of this 'model' status during the turbulent decade of the 1990s. Within this trajectory towards becoming a 'development model' and a women's health success story, population and women's health emerged as interconnected categories in policymaking.

Chapter 2 provides the institutional history of family planning. Through an account of the early family planning efforts in the 1930s, pioneers of the FPA, global politics behind the funding of family planning programmes in the 1950s, and the Sri Lankan state taking the responsibility for planning families in the mid-1960s, I set out the institutional history

of the family planning programme of Sri Lanka, from a fragmentary birth control movement to the re-branding of family planning as ‘reproductive health’ after the United Nation’s ICPD in 1994. In so doing, this chapter shows how the ‘cult of population control’ replaced the maternalist welfare ideology in Sri Lanka by the 1970s and became the official ideology defining women’s health by the 1980s.

Chapter 3 uses the history of ‘the Pill’ in Sri Lanka to show how the broader global discourse on population control played out in the Sri Lankan national context. It explores the fraught story of Sri Lanka as a site for Pill trials in the 1960s, and popular reactions to the widespread availability of the Pill by the mid-1970s. In particular, this chapter explores how universal population control as a development discourse of the state came under strain when confronted by the challenges of maternalist policies in an ethnically divided nation. Through a cross-reading of Sri Lankan research reports and the correspondence of pioneers of Sri Lankan and international family planning, I show how Sri Lanka entered the global Pill trials as a laboratory site, which prompted a discussion on contraception. I also explore the moral values around women’s bodies and ethnicity, which resulted in the Pill being termed *vanda beheth* (pills of sterility) in the late 1960s. Further, through my analysis of International Planned Parenthood Federation (IPPF) reports on the marketing programme for the contraceptive *Mithuri* (Female Friend) in 1974, contemporary Sinhalese and English newspaper articles, advertisements and interviews with one of the earliest Ayurvedic physicians trained in family planning methods in 1974, one of Chinnatamby’s⁶⁶ students and Chinnatamby’s successor at the FPA, I show how women’s health and bodies became the ground on which market forces (*Mithuri*) replaced ethnic forces (*vanda beheth/pethi*).

Chapter 4 retells the history of the turbulent 1990s, and how its economic, military and political policies sidelined issues of women’s health. Until the 1990s, the women’s health agenda of Sri Lanka and the international development and population control agenda, although not identical, co-existed in mutual intelligibility and instrumentality. During the fraught 1990s, the Sri Lankan state re-framed and mobilised women and their bodies through ideologies and discourses of ‘patriarchy’ and ‘motherhood’ in response to the economic, political and governmental

turmoil of the decade. Chapter 4 in a way acts as a preface to Chapter 5. By pointing out the different tropes of ‘motherhood/womanhood’ (docile girls at the FTZs, brave mothers in the Gulf and the mothers of war heroes) and the human rights violations of the 1990s, I argue that Sri Lanka was not in an appropriate mind-set to introduce the paradigm shift in women’s health—reproductive health and rights—advocated at the ICPD in 1994.

In Chapter 5, I argue that the launching of the island-wide WWC programme in 1996 and the designing of the Population and Reproductive Health Policy in 1998 as consequences of the ICPD were both problematic and ambitious ventures, because in an environment where human rights are routinely undermined, just like in the 1990s Sri Lanka, it is unlikely, if not impossible, to even ‘imagine’ reproductive rights. Furthermore, due to the state’s framing of women’s bodies for social reproduction as a response to the turbulent events of the 1990s, neither women nor bureaucrats or doctors were free to ‘imagine’ the new ideology of women’s health ‘beyond reproduction’.

This is an attempt to write a critical history of women’s health in post-independence Sri Lanka by challenging the ‘success story’ put forward by development economists, demographers and public health officers. This is neither a history of the FPA nor a demographic history, but a careful analysis of the women’s health programme as state strategy in twentieth-century Sri Lanka. By bringing the discourses on the woman’s body and women’s health into a unified analytical framework, I was not only able to foreground the subjugated stories of women’s corporeal experiences, but was also able to broaden the understanding of women’s health in Sri Lanka. I conclude this book by suggesting that this is the right moment for Sri Lanka (after the end of an ethnic war) to put forward an all-encompassing reproductive health and rights approach towards women’s health by releasing the woman’s body from its development, national and ethnic obligations.

NOTES

1. A. Marwick, *The New Nature of History: Knowledge, Evidence, Language*, Basingstoke, Hampshire, Palgrave Macmillan, 2001, p. 29.

2. M. Foucault, *The Archaeology of Knowledge and the Discourse on Language*, tr. A. M. Sheridan Smith, New York, Pantheon Books, 1972, p. 25.
3. D. Kirk, 'Natality in the Developing Countries: Recent Trends and Prospects', in *Fertility and Family Planning a World View*, eds S. J. Behrman, L. Corsa and R. Freedman, Michigan, The University of Michigan Press, 1969, p. 80; J. C. Caldwell, I. Gajanayake, B. Caldwell and P. Caldwell, 'Is Marriage Delay a Multiphasic Response to Pressures for Fertility Decline? The Case of Sri Lanka', *Journal of Marriage and the Family* 51 (2), 1989, pp. 337–51; I. Alam and J. C. Cleland, *Illustrative Analysis: Recent Fertility Trends in Sri Lanka*, World Fertility Survey Scientific Report No. 25, International Statistical Institute, Voorburg, 1981; and G. Myrdal, *Asian Drama: An Inquiry into the Poverty of Nations*, Vol. II, New York, Pantheon, 1968.
4. G. Corea, 'Ceylon in the Sixties', *Marga Quarterly* 1 (2), 1971, p. 2.
5. Myrdal, *Asian Drama*, Vol. II, p. 1408.
6. K. Jayawardena, *Feminism and Nationalism in the Third World*, London, New Jersey, Zed Books Ltd, 2003, p. 118. See also S. Jayaweera, 'Women in Education and Employment: Fifty Years in Retrospect', in *Women in Post-independence Sri Lanka*, ed. S. Jayaweera, New Delhi, Sage, 2002, for the history of women's education in Sri Lanka.
7. Jayawardena, *Feminism and Nationalism*, p. 121.
8. Myrdal, *Asian Drama*, Vol. II, 1968, p. 1419.
9. G. Myrdal, *Asian Drama: An Inquiry into the Poverty of Nations*, Vol. III, New York, Pantheon, 1968, p. 1569.
10. Myrdal, *Asian Drama*, Vol. II, p. 1419. Ceylon became Sri Lanka in 1972 when it became a republic within the Commonwealth. Since both terms refer to the same geographical entity, I use the terms Ceylon and Sri Lanka interchangeably in my book.
11. W. D. Lakshman and C. Tisdell, 'Introduction to Sri Lanka's Development Since Independence', in *Sri Lanka's Development Since Independence: Socio-economic Perspectives and Analysis*, eds W. D. Lakshman and C. A. Tisdell, New York, Nova Science Publishers, 2000, p. 5.
12. Caldwell et al., 'Is Marriage Delay a Multiphasic Response to Pressures for Fertility Decline?'
13. Myrdal, *Asian Drama*, Vol. II, p. 1422.
14. For a history of the Family Planning Association (FPA) of Sri Lanka, see O. E. R. Abhayaratne and C. H. S. Jayewardene, *Family Planning in Ceylon*, Colombo, The Colombo Apothecaries Ltd., 1968; N. H. Wright, 'Early Family Planning Efforts in Sri Lanka', in *The Global Family Planning Revolution: Three Decades of Population Policies and Programmes*, eds W. C. Robinson

- and J. A. Ross, Washington DC, World Bank, 2007, pp. 341–62; and K. Jayawardena, *Dr. Mary Rutnam: A Canadian Pioneer for Women's Rights in Sri Lanka*, Colombo, Social Scientists' Association, 1993.
15. Walt Whitman Rostow became professor of economic history at the Massachusetts Institute of Technology (MIT) in 1950. A year later, he received a dual appointment as a professor at MIT's Center for International Studies funded by the Central Intelligence Agency (CIA). In 1960, Rostow became the deputy special assistant for national security affairs in the Kennedy administration. From 1961 to 1966, he was the chairman of the Policy Planning Council under the administrations of both John F. Kennedy and Lyndon B. Johnson, who became the President following Kennedy's assassination in November 1963. Further, he played a prominent role in shaping US foreign policy in South East Asia in the 1960s. See http://www.anb.org/articles/14/14-01158.html?from=../07/07-00152.html&from_nm=Kennedy%2C%20John%20Fitzgerald (accessed on 18 July 2024).
 16. D. Hodgson, 'Demography as Social Science and Policy Science', *Population and Development Review* 9 (1), 1983, p. 2.
 17. The demographic transition theory was introduced in 1929 by American demographer Warren Thompson through his careful study of birth and death rates of industrialised countries over a period of 200 years. This was further developed in the late 1940s by Frank Notestein and Kingsley Davis of the Office of Population Research at the University of Princeton. According to Notestein and Davis, the modern demographic transition theory means that 'the shift towards low mortality and fertility rate occurs when there is a process of overall modernisation resulting from industrialisation, urbanisation, education, empowerment of women, as well as substantial overall socio-economic development'. See *The State of Demographic Transition in Africa*, ECA/FSSDD/01/10, Food Security and Sustainable Development Division (FSSDD), December 2001, p. 1.
 18. S. Greenhalgh, 'The Social Construction of Population Science: An Intellectual, Institutional, and Political History of Twentieth-Century Demography', *Comparative Studies in Society and History* 38 (1), 1996, p. 36; and J. Caldwell, 'Toward a Restatement of Demographic Transition Theory', *Population and Development Review* 2 (3/4), 1976, p. 323.
 19. According to Rostow, in order to become a capitalist society, every society has to go through five stages of growth: from traditional society, to the preconditions for take-off, then the take-off, then the drive to maturity, and the final stage of high mass consumption.

20. Sweden's development cooperation with Ceylon/Sri Lanka commenced in 1958 in the field of family planning, and thus the cooperation between Sweden and Sri Lanka took place before the creation of the Swedish International Development Cooperation Agency (SIDA). The first Swedish government aid agency was created in 1962 and was reorganised in 1965 to become the Swedish International Development Authority (SIDA), which was again reorganised in 1995 to become the Swedish International Development Cooperation Agency. For more information, see P. K. J. Thaarup, 'Long Term Development Cooperation between Sri Lanka and Sweden', UTV Working Paper, 2010:11, SIDA, 2010.
21. J. C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, New Heaven and London, Yale University Press, 1998, p. 2.
22. Ibid.
23. P. Lukumar and A. Pathmeswaran, 'Factors Associated with Home Deliveries in Thampalakamam, Trincomalee', *The Ceylon Medical Journal* 51 (2), 2006, 59–62; N. de Silva, 'A Study of Emotional Disorders in Women Patients in General Practice', unpublished Ph.D. dissertation, Post-Graduate Institute of Medicine, Colombo, 1989; S. M. P. Chandrarathne, 'Effect of Antenatal Body Mass Index on Maternal and Fetal Outcome', unpublished Ph.D. dissertation, Post-Graduate Institute of Medicine, Colombo, 2004; and K. N. J. Fernando, 'Knowledge and Practices on Contraception Among Married Female School Teachers in Udunuwara MOH Area and the Use by Them of Available Family Planning Services', unpublished Ph.D. dissertation, Post-Graduate Institute of Medicine, Colombo, 1999; and H. Seneviratne and L. Rajapakse, 'Safe Motherhood in Sri Lanka: A 100 Years March', *International Journal of Gynaecology and Obstetrics* 10 (1), 2000, p. 116.
24. My interviews/conversations with the Chairperson of the women's research committee at the Sri Lanka Medical Association and lecturers on the medical faculty on different occasions over the past six years, from 2008 to 2014, testify that there are very few studies done on health-related issues from a social science perspective. From their experience on the medical faculty in Sri Lanka, my informants said that medical students prefer research from a clinical perspective, giving preference to lab work and quantitative methods, as they are not trained to look at the human body as a subjective phenomenon.
25. A. de Silva, (co-author with multiple authors), *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*, Human Development Network, Health, Nutrition and Population Series, World Bank, Washington, 2003, and 'Overview of the Health Sector', in *Economic Policies in Sri Lanka: A*

- Festschrift in Honour of Gamini Corea*, ed. S. Kelegama, New Delhi, Sage Publications, 2004; D. T. P. Liyanage and R. D. A. Seneviratne, 'Evaluation of Cervical Screening Coverage in Kalutara District', *Journal of College of Community Physicians of Sri Lanka* 14 (1), 2009, pp. 33–38; S. Suraweera, R. D. A. Seneviratne and H. M. S. S. D. Herath, 'Prevalence of Occupational Stress in Selected Categories of Employees in Domestic Commercial Banks in a District of Sri Lanka', paper presented at the International Conference on Psychosocial Factors at Work, Bangkok, 2009; and C. Abeysena, P. Jayawardena and R. D. A. Seneviratne, 'Maternal Sleep Deprivation is a Risk Factor for Gestational Age: A Cohort Study', *Australian and New Zealand Journal of Obstetrics and Gynaecology* 49 (4), 2009, pp. 382–87.
26. Scott in *Seeing Like a State* (1998) uses the term *métis* to refer to the knowledge that can come only from practical experience.
 27. K. Davis (ed.), *Embodied Practices, Feminist Perspectives on the Body*, London, New Delhi, Sage Publications, 1997, p. 4.
 28. R. Wertz and D. C. Wertz, *Lying-In: A History of Childbirth in America*, New York, Free Press, 1977; and L. Gordon, *Woman's Body, Woman's Right: A Social History of Birth Control in America*, New York, Viking Press, 1976.
 29. A. Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women*, Oxford, Basil Blackwell, 1984.
 30. Davis, *Embodied Practices*, p. 6. For feminist debates on women's health, see B. Ehrenreich and D. English, *For Her Own Good: 150 Years of Expert's Advice to Women*, London, Pluto Press, 1979; Helen Roberts, *Women, Health and Reproduction*, Henley on Thames, Routledge, Kegan and Paul, 1981; R. Bleier, *Science and Gender: A Critique of Biology and its Theories on Women*, Oxford, Pergamon Press, 1984; E. Lewin and V. Olesen, *Women, Health and Healing: Towards a New Perspective*, New York, Tavistock, 1985; E. F. Keller, *Reflections on Gender and Science*, New Heaven, Yale University Press, 1985; E. Showalter, *The Female Malady*, London, Virago, 1987; L. Jordanova, *Sexual Vision: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries*, New York, Harvester Wheatsheaf, 1989; and L. Scheibinger, *The Mind Has No Sex: Women in the Origins of Modern Science*, Cambridge, MA, Harvard University Press, 1989.
 31. Davis (ed.), *Embodied Practices*, p. 5.
 32. S. Bordo, 'Feminism, Foucault and the Politics of the Body', in *Up Against Foucault: Explorations of Some Tensions between Foucault and Feminism*, ed. C. Ramazanoglu, Routledge, 1993, p. 193.
 33. Jayaweera, 'Women in Education and Employment'; and Jayawardena, *Feminism and Nationalism in the Third World*.

34. S. Bordo, *Unbearable Weight: Feminism, Western Culture and the Body*, Berkley/Los Angeles/London, University of California Press, 1993; S. L. Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression*, New York and London, Routledge, 1990.
35. Bartky, *Femininity and Domination*, p. 79.
36. Bordo, 'Feminism, Foucault and the Politics of the Body', p. 191.
37. E. Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston, Beacon Press, 1987, pp. 54–67.
38. 'Biopower and the Limitations of Mainstream Feminist Activism', 16 February 2012, available at <http://pittfemtheorys12.wordpress.com/2012/02/16/biopower-and-the-limitations-of-mainstream-feminist-activism/> (accessed on 18 July 2024).
39. P. Rabinow (ed.), *The Foucault, Reader, An Introduction to Foucault's Thought*, London, Penguin Books, 1991, p. 263.
40. M. Foucault, 'Society Must Be Defended': *Lectures at the College de France, 1975–76*, eds M. Bertani and A. Fontana, tr. by David Macey, New York, Picador, 2003, p. 241.
41. See J. Sawicki, *Disciplining Foucault: Feminism, Power and the Body*, New York, London, Routledge, 1991; G. Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*, New York, Harper & Row, 1985; Ehrenreich and English, *For Her Own Good*; Gordon, *Woman's Body, Woman's Right*; D. Roberts, *Killing the Black Body: Race Reproduction and the Meaning of Liberty*, New York, Pantheon Books, 1997; R. Petchesky, *Abortion & Woman's Choice*, New York, Longman Press, 1984; C. Dreifus, *Seizing Our Bodies*, New York, Vintage Books, 1978; M. Stanworth (ed.), *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge, Polity Press, 1987; M. McNeil, Ian Varcoe and Steven Yearley (eds), *The New Reproductive Technologies*, London, Macmillan, 1990; J. Van Dyck, *Manufacturing Babies and Public Consent: Debating the New Reproductive Technologies*, London, MacMillan, 1995; R. A. Charo, 'Problems in Commercialised Surrogate Mothering', *Women & Health* 13 (1, 2), 1987, pp. 195–201; and G. Corea, 'The Reproductive Brothel', in *Man-Made Women: How New Reproductive Technologies Affect Women*, eds G. Corea, R. D. Klein, J. Hanmer, H. B. Holmes, M. Kishwar, J. Raymond, R. Rowland and R. Steinbacher, Bloomington, Indiana University Press, 1987, pp. 33–51.
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47. See R. Coomaraswamy, 'Integration of the Human Rights of Women and the Gender Perspective: Violence against Women,' Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, submitted in accordance with Commission on Human Rights resolution 2002/52, Economic and Social Council, United Nations, 2003; de Alwis, 'The Moral Mother Syndrome'; de Mel, 'Body Politics,' and *Militarizing Sri Lanka*.
48. Valisingha Harischandra, S. Mahinda Thero of Tibet and Henry Steel Olcott, to name a few nationalists of the day.
49. It provided detailed advice for the laity on general etiquette and dress. Lay people were given instructions under 22 headings, such as how to behave during meals, how to travel in public transportation, on wearing clean clothes and good toilet habits. Out of these, 30 rules were laid down on how women should behave and their duties towards the family. In general, these rules give a clear picture of Dharmapala's intention of social reform; he touches upon all the aspects of the laity's life. By 1958, 49,500 copies of the pamphlet were sold. See Ananda Guruge (ed.), *Dharmapala Lipi*, Colombo, Government Press, 1965, p. 31.
50. Chatterjee makes this point quite succinctly on Indian nationalism in his seminal work, *The Nation and its Fragments*.
51. See <http://www.accu.or.jp/litdbase/policy/lka/index.htm> (accessed on 18 July 2024).
52. K. Jayawardena, *Feminism and Nationalism in the Third World*.
53. Coomaraswamy ('Integration of the Human Rights of Women') questions whether the enrolment of women in the ranks of the LTTE meant women's emancipation or the strengthening of the organisation. N. de Mel argues that the female body has been used by the LTTE to achieve its political agenda by training women to be suicide bombers. This act, which could be characterised as unfeminine, was justified within traditional lines—protecting their motherland for the future children of the nation. In response to this, M. de Alwis explores the state discourse on the moral Oriental mother, despite the violence it connotes in order to fulfil the political agendas of the state. See de Alwis, 'The Moral Mother Syndrome'; N. de Mel, 'Agent or Victim? The Sri Lankan Woman Militant in the Interregnum,' in *Feminists under Fire*:

Exchanges across War Zones, eds Wenona Giles, Malathi de Alwis, Edith Klein and Neluka Silva, Toronto, Canada, Between the Lines, 2003.

54. S. Thiruchandran, *The Other Victims of War: Emergence of Female Headed Households in Eastern Sri Lanka*, Vol. 2, Colombo, Women's Education and Research Centre, 1999; S. Kottegoda, *Negotiating Household Politics: Women's Strategies in Urban Sri Lanka*, Colombo, Social Scientists' Association, 2004; C. Lynch, *Juki Girls, Good Girls: Gender and Cultural Politics in Sri Lanka's Global Garment Industry*, Ithaca and London, Cornell University Press, 2007; and S. Hewamanne, *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*, Philadelphia, University of Pennsylvania Press, 2008.
55. M. Jegathesan, *Tea and Solidarity: Tamil Women and Work in Postwar Sri Lanka*, Seattle, University of Washington Press, 2018.
56. The director of the resource centre at the FPA retrieved some old annual reports for me from senior retired members of the FPA by contacting them personally, since some library copies had been destroyed due to floods in 2003.
57. I have footnoted some of these experiences in Chapters 2 and 5 and provided an analysis of these interviews with medical professionals.
58. Please see my article, "Medical Doctors Do Not Accept Any Refreshment from Us": Oral History Interviews in a Medical Setting in Sri Lanka, *The Oral History Review* 45 (2), 2018, pp. 255–77.
59. Please see Thoradeniya, "Medical Doctors Do Not Accept Any Refreshment from Us" for an insightful analysis of trespassing epistemic and disciplinary boundaries.
60. C. G. Urugoda, *A History of Medicine in Sri Lanka from the Earliest Times to 1948*, Colombo, Sri Lanka Medical Association, 1987; and K. T. Silva, *Decolonisation, Development and Disease: A Social History of Malaria in Sri Lanka*, New Delhi, Orient BlackSwan, 2014.
61. See A. C. G. M. Robben and J. A. Sluka (eds), *Ethnographic Field Work: An Anthropological Reader*, Wiley Blackwell Publishers, 2007; and R. Madden, *Being Ethnographic: A Guide to the Theory and Practice of Ethnography*, Newbury Park, Sage, 2010.
62. K. Visweswaran, *Fictions of Feminist Ethnography*, New Delhi, Oxford University Press, 1996, p. 8.
63. A. Portelli, 'What Makes Oral History Different', in *The Oral History Reader* (2nd edn), eds Robert Perks and Alistair Thomson, London and New York, Routledge, 2006, p. 36.
64. B. Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control*, Boston, South End Press, 1995 [1987], p. 104. Hartmann

uses the phrase 'cult of population control' to analyse how everybody, from policymakers to policy recipients at the grassroots level, believes in development through population control. I find this an ideal phrase to use about the mind-set of the population policymakers of independent Sri Lanka.

65. See studies by S. Hewamanne, *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*, Pennsylvania, University of Pennsylvania Press, 2007; and M. R. Gamburd, *The Kitchen Spoon's Handle: Transnationalism and Sri Lanka's Migrant Housemaids*, New York, Cornell University Press, 2000.
66. Dr Siva Chinnatamby is the lady gynaecologist (medical director of the FPA Ceylon) who conducted Pill trials in Sri Lanka in 1961.

Ceylon Becoming a Development Model (1950–90)

INTRODUCTION

As pointed out in the Introduction, internationally renowned demographers, development economists and health experts hailed Sri Lanka as a ‘development model’ for South Asia by the 1970s due to its low fertility and mortality levels, increasing life expectancy, high women’s literacy rate, women’s empowerment and sound public health services.¹ It is clear that one of the drawbacks of these favourable social indicators was that the population was brought under surveillance, especially those sections that the First World considered ‘problem populations’ of the Third World.² In other words, independent Sri Lanka emerged as a ‘development model’ for South Asia mainly because of its steady control of the population growth rate due to state-initiated welfare policies such as free education and public health services. Since population is seen in the development discourse as one of the main determinants of development, women’s health emerged as the primary development indicator for evaluating the state-building project of independent Sri Lanka. By saying so, I do not wish to disregard the other determinants of development, such as programmes on poverty, primary health care and economic development that were implemented in post-independence Sri Lanka.

This chapter examines what development discourse produces in relation to women’s health in Sri Lanka, that is, the erasure of the possibility of imagining women’s health and bodies ‘beyond reproduction’. As a

consequence, women's health remains limited to reproduction and is articulated in terms of numbers, trends and projections that paint a positive picture about women's status and health in Sri Lanka. This chapter provides an introduction to and overview of the trajectory of Sri Lanka's women's health from its 'success story' in the 1970s to the crisis situation of the 1990s. I argue that by failing to achieve development during the past six decades, this 'model' status has not only become a fallacy today, but also silenced women's bodies by denying them reproductive rights.

The first part of this chapter examines how Sri Lanka became a case study and then a 'model' for South Asian countries in the global population and development debate. The second part examines how population was addressed in official Sri Lankan rhetoric in order to achieve the so-called 'model' status. I will examine the emergence of population as a 'question' in census reports and as a 'problem' in development plans, and how population planning became an integral part of the national planning ideology of the late 1950s. The third part of this chapter questions the official—institutional and policy-making—response to the population 'problem' of the state. Even though measures had been introduced earlier to curb the population growth rate, it took four decades for the state to formulate a population policy. Finally, the fourth part provides an overview of the political and economic context of 1990s Sri Lanka in order to show why the reproductive health and rights approach could not be achieved in women's health discourse in the 1990s.

SRI LANKA BECOMING A 'CASE STUDY' WITHIN POPULATION RESEARCH

Before Sri Lanka became independent in 1948, it was seen as a 'model colony' of the British Empire. According to the nation's most eminent historians, Sri Lanka's claim to self-government was justified on the grounds that

it was not merely a special case but an unusual one as well because of the strength of her civil society, the political maturity and sophistication of her leaders, and above all the fact that she had had adult suffrage for nearly two decades.³

By the time of independence, its model colony status had acquired a new significance. Initially, Sri Lanka came onto the radar of international researchers with the success of its mortality control; Ceylon was considered a 'true laboratory for demographic research'.⁴ Researchers sought to understand the relationship between a drastic decline in mortality rates by 1947 and the malaria control programme launched in 1945 by residual spraying of DDT. They sought to situate both alongside the advances made by the country's civil society. Sri Lanka's mortality rate (deaths per 100,000 people) was brought down from 187.3 in 1946 to 66.1 in 1947.⁵ This was largely attributed to efficient anti-malaria campaigns launched in 1946.⁶ According to a study by the Marga Institute commissioned by the United Nations Research Institute for Social Development (UNRISD), due to this decline in mortality and a stable birth rate, the population growth rate rose from 1.4 in 1945 and 1.8 in 1946, to 2.5 in 1947 and 2.7 in 1948. With net migration, the growth of population reached 3.0 per cent, 3.1 per cent and 3.2 per cent in the years 1948–49, 1949–50 and 1950–51, respectively.⁷

Before long, Sri Lanka also became a site of fertility control and international enquiry. This was indeed the opposite of the Western experience. Without any state policy intervention, death rates went through a steady decline in relation to economic progress and industrialisation, which was followed by improved living conditions. Demographers such as Abhayaratne (1950), Cullumbine (1950), Davis (1956), Frederiksen (1961), Gray (1974), Jones and Selvaratnam (1972), MacDonald (1951) and Newman (1965, 1970) found this new demographic situation in Sri Lanka an interesting case study for a newly independent agricultural state.⁸

Since many of these demographers believed that rapid population growth was the root cause of poverty, population control measures and policies were introduced to the Third World by the West as the first step towards development.⁹ With technical and financial assistance from international development agencies such as the Swedish government, the International Planned Parenthood Federation (IPPF), the World Health Organization (WHO) and the United Nations Fund for Population Activities (UNFPA), Sri Lanka soon adopted the dominant development ideology and thinking on global population discourse.

Concurrently, the Population Association of America (PAA), established in 1930, carried out population research in developing countries, which legitimised population as a subject of scientific research.¹⁰ Eminent academics who participated in the First World Population Conference held in Rome from 31 August to 10 September 1954 decided to

generate fuller information on the demographic situation of the developing countries and to promote the creation of regional training centres which would help to address population issues and to prepare specialists in demographic analysis.¹¹

Following this, population study centres were established at American universities through Ford Foundation grants in the early 1950s. Quoting Hodgson, Greenhalgh points out that 'in one decade, between 1951 and 1961, seven new programs were funded; in another six years, between 1961 and 1967, nine more were added'.¹² As Hartmann puts it, the Ford Foundation, the Population Council and the Rockefeller Foundation facilitated the development of 'a powerful cult of population control' in US academia, which led to the myth of overpopulation in the 1960s, 'a philosophy based on fear, not understanding'.¹³ Research centres were set up, researches were funded and conferences were held to discuss the findings and to make population policy decisions for the Third World, thus creating a discourse on population and development. From the process, demography emerged as a modern science while the populations of Third World countries became research sites and research subjects.

By the 1950s, populations on research sites were computed and analysed according to the demographic transition theory and the results were used to design development plans for the regions under study. During the golden decades (1960s, 1970s) of American demography, Stanford University biologist Paul Ehrlich introduced the term 'population bomb' to describe the rapid population growth in Asia.¹⁴ As a result of the population boom in post-War Ceylon, Jones and Selvaratnam say that Sri Lanka became subjected to academic scrutiny in the 1960s, and this trend further popularised the term 'population explosion'.¹⁵ According to Corea, Lakshman and Tisdell, Sri Lanka stood out in the Asian demographic picture because the population growth rate was brought under control

(nearly 3 per cent per annum in the late 1950s to about 2.2 per cent by the late 1960s)¹⁶ as a result of the improvements in social indicators such as high literacy rates, rise in female age at marriage, women's employment and family planning activities.

Thus, by the late 1960s, Sri Lanka turned out to be a case of interest and a puzzle for scholars of not only demography but also economics and development studies. Though its social indicators were well above the standards of other developing countries, economic progress was still alarmingly slow. In comparison to other developing countries, Sri Lanka became identified as an 'outlier'.¹⁷

Prior to questioning Sri Lanka's 'model' status in South Asia, it is important to give a brief history of the development of demography as a discipline in Sri Lanka.

HISTORY OF DEMOGRAPHY IN SRI LANKA

Demography developed as a discipline in Sri Lanka in the early 1970s. The Demographic Training and Research Unit (DTRU) was established in 1973 at the Faculty of Arts of the University of Sri Lanka (now University of Colombo) with the assistance of the UNFPA. The first set of young demographers was trained mainly by the Australian National University.¹⁸ One of the main objectives of the DTRU was to 'encourage the scientific study of population besides teaching population courses at the university'.¹⁹ The major aim and long-term objective of the Unit was

to promote the understanding among policy makers and planners that there are inter-relations between demographic changes and socio-economic factors. This project was considered by the first Director of the DTRU as 'the academic backbone in the country to develop, modify and evaluate population policies for the Government'.²⁰

During the 1970s and 1980s, global demographic research incorporated anthropological research methods in order to understand the discrepancies between demographic predictions based on demographic transition theory and actual demographic findings. Studies were undertaken by Australian demographer John Caldwell, together with the Sri Lankan

demographer Indra Gajanayake, on the change in marriage patterns in Sri Lanka during 1985 and 1987 in order to understand its impact on fertility trends. This demographic study for the first time used a combination of survey and anthropological methods.²¹ With a new zeal in demographic research, demographers tried to find trends, special cases and best models in the Third World and provided demography with new legitimacy as a social science.

IS SRI LANKA ACTUALLY A 'DEVELOPMENT MODEL'?

Studying these trends in the 1970s, demographers identified Sri Lanka as a 'development model' or a template which other countries in the region should follow. But, of course, the model was not free of its own problems.

The first demographic study of Sri Lanka, published in 1956 by N. K. Sarkar, stated that Ceylon had many features in common with other Asian countries and it also possessed 'an unusual wealth of demographic data'.²² However, he did not explain in detail what the 'unusual demographic data' was, assuming that it was general knowledge in academia at that time. He also claimed that this was the reason why Sri Lanka became a case of interest to Western demographers. According to the WHO, the rise in life expectancy at birth between 1946 and 1954 (an increase of 15 years from 44 years to 59 years) was 'an unparalleled achievement in world demography'.²³ Sarkar may have been referring to this as the unusual demographic data in his article published in 1956. In any case, from the 1960s onwards, there was a growing consensus among demographers that Sri Lanka's remarkable demographic performance was the result of the colonial legacy of a sound public education and health system.

Writing in 1969 about fertility trends in developing countries, Dudley Kirk, professor of demography at Stanford University, found 'Ceylon as an interesting case, a sort of Ireland of Asia, in which late marriage has reduced natality'.²⁴ The Sri Lanka Fertility Survey conducted in 1975 (as part of the World Fertility Survey Programme) supported this statement and 'spread the fame of Asia's Ireland ...'.²⁵ Similar views were held by demographers such as N. H. Wright and D. F. S. Fernando on the relationship between the rise in female age at marriage and the decline in population growth.²⁶

Caldwell et al. (1989) identified Sri Lanka as the leader in Third World Asia's change in marriage patterns; by the mid-1970s, Sri Lankan females were marrying not at puberty but a decade later. There have been several studies of age at marriage, or its relative contribution to lower fertility in Sri Lanka.²⁷

Further, de Silva notes that, 'unlike India, Sri Lanka never had the custom of child marriage, premarital pregnancies are rare, and marital dissolution is insignificant...', thus age at marriage is the determinant of a woman's total reproduction.²⁸

According to G. Jones and S. Selvaratnam, who were writing in the early 1970s, 'Ceylon has been a forerunner for the countries of Southern Asia in many matters related to social and economic development.'²⁹ First, there was a sharp decline in mortality in the late 1940s; second, Sri Lanka had excellent social welfare services unmatched anywhere in the region; and third, a severe foreign exchange problem emerged by the 1970s. All these experiences made Sri Lanka suitable to be studied as a model in the region.³⁰

Taking life expectancy into consideration, S. L. N. Rao said in the 1970s, 'Sri Lanka occupies a place of pride along with Japan, Mauritius and Mexico in achieving phenomenal increases in life expectancy since the post-war period.'³¹ W. D. Lakshman and C. A. Tisdell noted that according to UNDP measures of 'countries of low human development' in 1998, the achievements of Sri Lanka in 1948 were relatively high by the standards of developing countries.³² Sri Lanka was much ahead in social indicators among South Asian countries.

However, despite its model status created by development experts, economists and demographers, Sri Lanka failed to live up to the promise of this legacy even by 2012. How do we understand the duality of reaching replacement-level fertility in 1994, six years prior to the estimate of the United Nations (UN),³³ and at the same time failing to achieve 'development' according to the 2012 United Nations Development Programme (UNDP) report? To answer this question, we need to dig further into the discourse and practices of population and development in Sri Lanka. Where did Sri Lanka 'go wrong' in its development trajectory, despite adhering to the approved path?³⁴ Or rather, was Sri Lanka trying to answer the wrong set of questions all along? What do the aforementioned examples imply?

At first, the qualities that make up Sri Lanka's exceptional status seem to imply a steady and gradual progress towards 'development', by keeping its population growth rate well under control. According to international and national demographers, Sri Lanka's demographic chart is very similar to that of modern Western developed countries. Then why was the promised development not achieved by Sri Lanka after adhering to the path set out by international development organisations? I believe Sri Lanka was trapped in the fallacy of believing in its 'model' status, which has painted a deceptive picture from the beginning. By saying so, I do not wish to disregard the claims made by renowned demographers based mainly on statistics. It is not the statistics or the method of acquisition or evaluation of those results that I question, but the conclusions made on the basis of these numbers. Due to the inherent link between population, women's health and women's bodies, it is difficult to treat population as the most crucial determinant of development. Population is not only about numbers, growth rates and providing the work force to develop the country, but it is also about women giving birth, women's bodies and their perception of being mothers and having families. Thus, the numbers, growth rates and work force mask a sensitive aspect of human lives, which has not been acknowledged by demographers, economists and development experts so far.

For over 50 years, population and development and the relationship between them were treated as closely related concepts by the West, and this connection had become an unquestionable truth: development could only be achieved if the population growth rate was controlled. Sri Lanka's demographical advancement was claimed as a universal truth by international demographers and was treated as gospel by local policymakers. Consequently, this led to the commonsensical presupposition, still prevalent in Sri Lanka, that women's health equals reproductive health, which needs to be carefully 'controlled and planned'. This in turn makes the woman's body an implicit category of analysis. In his intellectual inquiry into the prevalent development ideology in Third World countries, Escobar says that population programmes made population an 'object' which needs vigilant scrutiny and careful planning for development purposes.³⁵ Thus, population programmes were carried out along technically correct, modern and scientific lines. Renowned demographers such as Frank Notestein, Kingsley Davis, Dudley Kirk

and John C. Caldwell did not see the other side of the numbers, and their implications for women's bodies, when these claims about Sri Lanka were put forward.

Seen through a scientific and rational lens, Sri Lanka's status as a 'model' in South Asia appears to be a fallacy, even though statistics and numbers provided its very basis. First, this 'model' status failed to deliver the promised 'development' even after six decades. Second, Sri Lanka claimed to be a development model despite not having a well-articulated population policy until the late 1990s. Should not population policy be the guiding mechanism for a country to reach its 'model' status? Though the 'question' of population was taken up in the census report of 1921, Sri Lanka took another four decades (till the 1960s) to address population as a 'problem' by incorporating family planning in the government's maternal and child health programme and seven decades (in the 1990s) to formulate a population policy. The Population and Reproductive Health policy was formulated only in 1998. I believe that control of the population growth rate without a population policy is in itself a demographic marvel. How was this done? Such a remarkable achievement calls for a thorough analysis of the intricate relationship between development and women's health.

According to the former medical director of the Family Planning Association (FPA) and retired secretary to the Ministry of Plan Implementation, during the 1970s and 1980s, unlike in the sterilisation camps of India in the mid-1970s, population initiatives in Sri Lanka were implemented in a non-coercive manner. Population policy initiatives, such as the social marketing of contraceptives and sterilisation incentives, were implemented as and when they were deemed appropriate by policymakers. In explanation, she also said that Sri Lanka was able to make use of a less intrusive approach because the FPA and the government had educated the public on family planning methods through public health workers.³⁶ However, the former medical director of the FPA did introduce sterilisation incentives in the early 1980s. This means that there were implicit coercive policy measures in place to control the population growth rate without really looking into the deeper implications of population growth, structure and composition. Eventually, this paved the way for Sri Lanka to become a 'model' for South Asia. Is this model status not rather ambiguous, then?

I see Sri Lanka not as a development ‘model’, but as an island caught between this fallacy created by the West and trying desperately to understand its own meaning of development, while grappling with its priorities, demands and expectations. Though there appears to be a considerable time lag between the introduction of population control measures and the formulation of a comprehensive population policy, prior to interrogating this delay, I deem it necessary to investigate how population was addressed in the official rhetoric of independent Sri Lanka. By tracing the genealogy of population policy in the post-colonial state, I argue that the delay in formulating a population policy was the result of the controlling and planning ideology that prevailed within the official rhetoric on population. In other words, the delay was the result of the official silence on women’s rights over their bodies and of the need to govern women’s bodies to achieve the development targets set by international organisations.

Unlike in India, economic or development planning was indeed a new exercise in independent Sri Lanka, which impacted democratic state-building, nationalism, modernisation and industrialisation. The next section illustrates how planning ideology was woven into the development plans of post-independence Sri Lanka, which identified population as a ‘problem’.

PLANNING AS AN IDEOLOGY

An early reference to ‘planning’ in Sri Lanka appeared in the Governor General’s address at the opening session of Sri Lanka’s first Parliament in 1947:³⁷ ‘My government realises that the future well-being of this country depends to a great extent on the sound development of its resources and that the first step in this direction is Planning.’³⁸ However, when analysing the Indian development planning process, Benjamin Zachariah points out that planning had been an influential driving force for newly independent countries already by the 1930s, due to its successes in the Soviet Union, Japan, the US, fascist Italy and Nazi Germany.³⁹

After World War II, the planning process was forcefully strengthened as America appeared as the model that less fortunate societies should follow; ‘America’s path to political stability and prosperity through the

rational management of its resources, through the application of science and technology to mass production' seemed the path to emulate to become a modern developed nation.⁴⁰ As I have mentioned earlier, with population studies gaining scientific status in the early 1950s, rapid population growth in the Third World came to be seen as the greatest obstacle to development. As Berly Suitters says, since the IPPF's aim was 'to make family planning a part of national development' in Third World countries, it worked out ways and means of providing them with funds for family planning programmes.⁴¹ Therefore, population control programmes were designed to control the rapid growth of 'problem populations' in the Third World. It became the moral obligation of the First World to facilitate development planning, with an emphasis on population programmes of the Third World for the greater good for a greater number. The International Bank for Reconstruction and Development (IBRD) did not hesitate to send 'experts' to help with the development planning process of the newly independent states of the Third World.⁴² As correctly pointed out by Majid Rahnema, the planning process of the Third World countries ended up making them 'as we (the first world) want them to be'.⁴³ Through this process, the Third World entered into a new imperial relationship with the First World.

Apart from the pro-West modern and capitalist mode of development planning, there was another set of ideologies that influenced the planning process of the newly independent states of Asia: the socialist model of self-sufficient planning where the state owns and regulates the resources in an egalitarian manner. Gunnar Myrdal pointed out that the idea of state ownership and mobilising the production forces of the country for a single cause created not only planning as an ideology, but also an emotional momentum of 'new nationalism' for Third World countries.⁴⁴ Partha Chatterjee describes this very succinctly in the Indian planning process. 'The very institution of a process of planning became a means for the determination of priorities on behalf of the "nation"'.⁴⁵ Further elaborating this point, he says that the development planning process helped to create a national consciousness across the nation.

In 1938, the Indian National Congress decided to set up the National Planning Committee (NPC). Consequently, development planning became part of the nation-building process of India.⁴⁶ However, Sri Lanka's National Planning Council was established only in 1957—nine years after

independence. The first document resembling a national plan, the *Six Year Programme of Investment*, was designed on request of the IBRD. It was based on the recommendations of the IBRD Mission in 1952.⁴⁷ Unlike the situation in India, there was no dynamic discussion among academics, civil servants, industrialists and politicians on national planning; the urge for economic planning in Sri Lanka came from international agencies and not as a local initiative. Montague de Silva notes that during 1954, there were approximately 46 international personnel engaged in various activities at the department of health in Sri Lanka.⁴⁸ Along with the expertise, development aid came to Ceylon in the form of technical and financial assistance in order to plan and implement development programmes and research.

By the late 1960s, the UK, USA and Canada had established institutions to further monitor these regions and make sure that their money and energy were productively used. Several development studies institutes were established in the UK, such as the Institute of Local Government Studies at Birmingham University, the Department of Overseas Administrative Studies at Manchester University and the Institute of Development Studies at Sussex University. These specialised institutions provided special courses in 'medicine, engineering, agriculture, fisheries, co-operatives, management, broadcasting and television, taxation, law, adult education, public administration, customs and excise and immigration'.⁴⁹ Apart from development studies in general, centres for South Asian studies in particular were set up at universities in London, Cambridge and Hull. In Canada, the Centre for Developing Area Studies at McGill University and the Institute for International Cooperation at the University of Ottawa looked into the problems of and undertook research on development programmes carried out in the Third World.⁵⁰ What were these institutions for? And why were these institutions established in the First World instead of the Third World where the 'problem' resided?

These institutions created an intellectual surveillance in the Foucauldian sense, where the elites (such as policymakers and academics) of Third World countries were brought into neo-colonial servitude. While it is not exactly true that they were unaware of their position of intellectual servitude, they did not make a conscious attempt to break free; this was especially true of the Sri Lankan elite. Indeed, it was

an enormous ideological-political struggle and task to break free from neo-colonial servitude and engage in a project of conscious planning to develop Sri Lanka in an essentially Sri Lankan way. Unlike in India, no radical political or national movement was ever conceptualised in Sri Lanka. No such movement emerged against the British even during colonial rule because the Sri Lankan elite had its own ways of assimilating itself to the power and rule of the British government.⁵¹ This explains why Mignolo's urge for an 'epistemic disobedience'—thinking and imagining beyond what is given and produced, and disregarding all conventions—seemed impossible in the Sri Lankan context.⁵² The moment peoples' thinking pattern and imagination are captured and destroyed in the name of scientific rational education, epistemic disobedience becomes a fallacy. The Sri Lankan elite in post-independence Sri Lanka were graduates of Oxbridge; their ideological servitude did not leave space for an epistemic disobedience.

By the early 1960s, planning committees had been created in each ministry, working according to a definitive plan or a programme.⁵³ This initiative shows that by the 1960s planning had become an ideology, integrated well into the state-building project of Sri Lanka. The planning ideology of the 1960s acted as the vehicle for the newly independent states to acquire the consciousness of modern developing nation-states. Development planning dealt with development problems; thus, population was identified as a 'problem' in the post-independence development plans of Sri Lanka.

EMERGENCE OF THE OFFICIAL RHETORIC ON POPULATION IN SRI LANKA

The sources that I use to determine the official rhetoric on population are the census reports of 1881, 1891, 1911, 1921, 1931 and 1946, and the development plans of post-independence Sri Lanka. Foucault's analysis of population in his genealogical tracing of the history of sexuality in Western civilisation shows that there is an intimate bond between the state, its population and the effort by the state to govern, regulate and monitor all variables of population.

One of the great innovations in the techniques of power in the 18th century was the emergence of 'population' as an economic and political problem: population as wealth, population as manpower or labour capacity, population balanced between its own growth and the resources it commanded. Governments perceived that they were not dealing simply with subjects, or even with a 'people,' but with a 'population,' with its specific phenomena and its peculiar variables: birth and death rates, life expectancy, fertility, state of health, frequency of illnesses, patterns of diet and habitation.⁵⁴

Both census reports and development plans have specific ways of moulding a scattered, disorganised and unsystematic people into populations and citizens. Modern censuses in the nineteenth century, especially during British colonial domination, tried to understand subjugated people as a population residing within a defined territory of land. Thus, censuses organised subjugated people on behalf of the state as a population. James Scott sees censuses as the state's creation of 'a complete inventory of its population.'⁵⁵ This was achieved through counting people and recording their names, ethnicity, caste, marital status, religion and wealth. Thus, the mode of understanding people in the colonies was according to a Western measurement. These measurements and statistics made the colony legible to the ruling colonial powers.⁵⁶ I see development plans designed in post-independence Sri Lanka as instruments, continuing to create the same legibility through monitoring, regulating and governing the populations of these newly independent states. The recording of mortality rates, fertility rates and migration rates serves the same purpose.

Thus, I see population, development and planning as a cluster of closely knit concepts, which gets its full meaning by feeding into each other. If one concept is left out from this cluster, then the others lose their comprehensive meaning. In this section, I will examine each concept one by one in order to decipher the official rhetoric of population in independent Sri Lanka.

In the remainder of this chapter, I will look at the official rhetoric of population in Sri Lanka in two distinctive phases: colonial Ceylon (from 1881 to 1955) and independent Sri Lanka (from 1955 to 1998). These periods were not decided according to the accepted divide marked by independence. Since the first development plan of 1955 speaks volumes about the formulation of the official rhetoric on population, instead

of the political events I decided to take the year of its inception as the watershed. The year 1998 marks the formulation of the first population policy in Sri Lanka. The colonial phase will be studied through the census reports of Ceylon and the independent phase through development plans, because the two sources address two different phases of the population rhetoric, namely 'population as a question' in census reports and 'population as a problem' in development plans. The main characteristics of population policy and its meaning under each government that has ruled since independence do not form part of this book, since population policymaking was neither a linear nor an innocent process, but a political one. In the next section I will unravel other trajectories of population policymaking in post-independence Sri Lanka.

POPULATION AS A 'QUESTION' IN CEYLON (1881–1955)

As I have mentioned earlier, though population was taken stock of on various occasions in ancient Sri Lanka under the kings and during the Dutch period, the first modern census took place as instructed by the secretary of state on 26 March 1871, simultaneously with Great Britain and Ireland.⁵⁷ According to the 1871 census report, there were 2,405,287 inhabitants of Ceylon.⁵⁸ Thereafter, population was taken stock of decennially until 1981.⁵⁹ Later, due to the ethnic conflict engulfing the north and the north-east (1983–2009), the affected areas were not included in some years. The last population census of the whole island was taken in 2023. The population of Ceylon numbered 2,759,738 persons in 1881, 3,007,789 persons in 1891,⁶⁰ 3,565,954 in 1901 (exclusive of military and shipping) and 4,110,367 in 1911.⁶¹

The 1911 census report compares the percentage of increase in population and also population density since the first census of 1871.⁶² For the first time, the term 'over-population' was used in the 1921 census report in relation to the density of the population. The '[c]rude density of Ceylon in 1921 was 178 persons per square mile.'⁶³ Further, explaining Malthusian theory, the census report of 1921 says that Ceylon has to deal with the question

why population is restricted.... Population is necessarily limited by the means of subsistence. But it is to a people's advantage to check its increase by other means than by death from starvation, and the more progressive races are now rather to be imagined as aiming at a higher standard of comfort, or an increased real income per head, than as continually pressing 'hard against the limits of the average food'.⁶⁴

Even though the report did not suggest that Ceylon was overpopulated in 1921, colonial officials were paying attention to the notion of overpopulation by measuring the population growth rate and means of subsistence. Emphasising the comfortable living conditions of more progressive races, the 1921 census report warns that if population increase was not checked by other means, people will die of starvation. Thus, the report seems to be based on the principles of population advocated by Malthus.

The 1946 census report clearly states that 'Ceylon by comparison cannot be set down as an overpopulated country'.⁶⁵ More importantly, it notes that the increase in population was alarming and any small disturbance in the villagers' normal equilibrium will bring them to near starvation.⁶⁶ Quoting Kingsley Davies, the 1946 census report suggests formulating a national population policy in accordance with 'international demographic planning based on an equalisation of resources and standards of living of different peoples'.⁶⁷ Emphasising the quality of the population, it proposes to develop an eugenic consciousness among people through the spread of information on informed sexual selection.⁶⁸ Although Ceylon was not considered an overpopulated country by 1946, it was keen to improve the quality of its population through the dissemination of information. The 1946 census proposed the planning of population growth by considering various aspects of population and advocated a demographic policy 'on the basis of detailed investigations of the various aspects of the population problem'.⁶⁹ By 1946, it was clear that population was not only about numbers in the census reports, but also about monitoring and planning without letting the population 'grow haphazardly'.⁷⁰

The next section discusses the emergence of population as a 'problem' within the development plans of post-independence Sri Lanka.

POPULATION AS A 'PROBLEM' IN SRI LANKA (1955–98)

The 1950s: Planning Mode

After independence, Sri Lanka entered a new development planning framework through the Colombo Plan, devised after a Commonwealth Consultative Committee Meeting held in September 1950 in London.⁷¹ Gunnar Myrdal, who worked closely with the design of the development plans of South Asia in the late 1950s, says that from the beginning, planning has been a technical process in Ceylon as well as in other South Asian countries. Initial planning documents of Sri Lanka, such as the *Six Year Plan of 1948* and the Colombo Plan of 1950, were not development plans that national plans were expected to conform to. According to S. Colombage and S. A. Karunaratne, the *Six Year Plan of 1948* was more or less an 'extension of the Budget Speech'⁷² presented by the first finance minister of independent Sri Lanka. The *Colombo Plan* worked as a framework for bilateral arrangements, the partnership concept of self-help and mutual help in the development process with the focal areas being human resource development and South-South cooperation.⁷³ Even though the *Colombo Plan* identified South and South-East Asia as the most densely populated areas of the world, no effort was taken to control the population growth in Sri Lanka. However, family planning efforts in India were supported by the *Colombo Plan*. According to N. K. Sarkar, and Colombage and Karunaratne, the *Colombo Plan*, the *International Bank Plan* and the *Six Year Programme of Investment* (1954/55 to 1959/60) emphasised the importance of agrarian economy and paid no attention to population growth rates.⁷⁴ Sarkar sees this as a wrong turn taken by the *Colombo Plan* in trying to expand the agrarian economy; it proposed industrialisation rather than diversification of the economy.⁷⁵ However, more than anything else, I believe the *Colombo Plan* helped to establish the ideology of planning the economy to achieve development in Sri Lanka.

The Minister of Finance in 1955, M. D. H. Jayawardena, explained the *Six Year Programme of Investment* (1954/55 to 1959/60) as 'an attempt to marshal the resources of men and materials in such a way as to derive the maximum benefit for our country. On these foundations we build our hopes for the future.'⁷⁶ Notions of state-building and nation-building

are both embedded in his reference to the 'marshalling of resources to build our country's future'. *The Six Year Programme of Investment* saw rapid population growth as a 'problem' and the solution suggested was not population control, but 'expansion in the productive capacity of the economy'.⁷⁷ However, the importance of family planning and educating parents on family planning (spacing and limiting the number of children) in order to bring up healthier babies was mentioned in the last paragraph of the maternal and child health section of the plan.⁷⁸ In that sense, rapid population growth was identified as a 'problem' for the development of the country and recognised in the *Six Year Programme of Investment*.

Within the planning rhetoric of Sri Lanka, the rising population growth rate was articulated as a hindrance for development in the *Ten Year Plan of Ceylon* (1959–68). Bandaranaike, who was elected prime minister in 1956, set up the National Planning Council in 1957 and invited a number of distinguished foreign economists to help design a comprehensive national development plan for Sri Lanka.⁷⁹ In fact, one whole section in the first chapter of the *Ten Year Plan* ('Population Change—The Ceylon Experience', pp. 7–14) is devoted to explaining Ceylon's population change and growth and also comparing it with that of the West in the nineteenth century. Why is it that a comparison with Western countries was so important to planning the development of Sri Lanka? As I have pointed out earlier, the ideological servitude of the planning officials of Sri Lanka did not allow them to think beyond or escape from the framework given by the West.

Despite its limitations, the *Ten Year Plan* assesses the population issue in an analytical manner. Comparing the Indian situation with Sri Lanka, it questions Ceylon's laid-back attitude towards its own grave 'population problem', despite the fact that the rate of population growth in India was half of Ceylon's in 1957 (percentage growth of population from 1953 to 1957 was 1.3 in India and 2.5 in Ceylon).⁸⁰ Acknowledging the population policies carried out in India, Japan and China as part of their planning goals, the *Ten Year Plan* engages with theoretical questions of how to come up with a population policy free from all forms of compulsion, and how to organise campaigns to disseminate information on methods of birth control and make birth control devices readily and cheaply available.⁸¹ The plan also suggests setting up a competent committee of enquiry to study the population problem at length and come up with specific population

control measures.⁸² Though the disparity between the population growth rate and economic growth rate was mentioned as the most crucial gap to be closed in order to attain development, there was surprisingly no indication of designing a population policy, only of the introduction of 'population control measures'.⁸³ The solution lay in investing in industry and maintaining welfare-state policies.

Though the FPA of Ceylon was established in 1953 as a non-governmental organisation, family planning was not yet incorporated into the government health programme in the 1950s. As I have mentioned in the Introduction, the relationship between the FPA and the government at this time could be best described as clandestine. The government supported the cause of family planning in numerous ways, but 'persistently refused to make any statement of policy, positive or negative, on the subject' due to its sensitivity.⁸⁴ The pioneers of the FPA and contemporary politicians knew each other on a personal level, but that did not translate into a public relationship.

After identifying population as a 'problem' in development plans, what was the official response? First, population policy measures such as the social marketing of contraceptives and sterilisation incentives were introduced in the 1970s, but there was no policy document prepared on population until 1998. Second, population was brought under the purview of the Ministry of Plan Implementation in 1978.⁸⁵ Third, the Population Information Centre (PIC) was opened within the Ministry of Plan Implementation in July 1979 to serve as a clearing house where population information was collected, documented and disseminated.⁸⁶

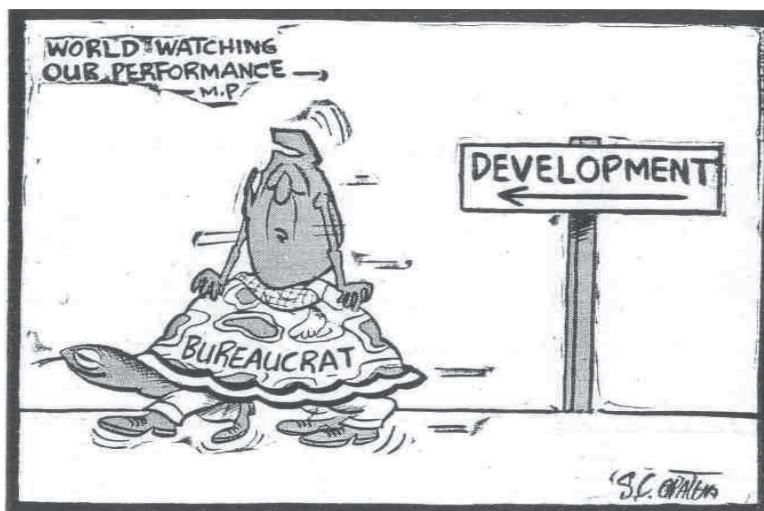
OFFICIAL RESPONSE TO THE POPULATION 'PROBLEM'

A closer look at the development planning process of post-independence Sri Lanka shows that institutional developments are part of population policy formulation. Thus, I discuss the three official responses of the state (mentioned earlier) in relation to the prevailing development planning ideology at the time.

I do not believe that the delay in formulating an official population policy meant that the issue of population was regarded as trivial. It was in

fact with great seriousness that the officials concentrated on implementing policy measures (some coercive) to reduce the population growth rate, rather than on formulating a population policy document. Thus, I see the delay in population policy formulation as a result of the state's keen interest in becoming a development 'model' to South Asia by controlling and planning women's health and silencing the woman's body (both her corporeal experiences and reproductive rights). The pressure that bureaucrats underwent to uphold this model status was well-captured by a cartoonist in an English daily in 1978 (see Image 1.1), titled, 'World is watching our performance'. The cartoon depicts a bureaucrat as a turtle who is leading Sri Lanka towards development. In that sense, institutional developments were actually part of the formulation of a population policy.

Image 1.1. Cartoon, 'World is Watching our Performance'.



Source: S. C. Opatha, Cartoon in the *Daily Mirror*, 21 August 1978, p. 4.

FORMULATION OF A POPULATION POLICY

The need for a population policy in Sri Lanka was first mentioned by Sarkar in an article published in *Population Studies* in 1956.⁸⁷ The author used 'population policy' and 'birth control policy' interchangeably in this article.

His suggested population policy was aimed at only one goal: reduce the fertility rate of Sri Lanka, which was increasing at a rapid pace (2.8 per cent) in the 1950s. In effect, he confined his population policy to stopping the birth of children. As a firm believer in the demographic transition theory, Sarkar said that a birth control policy should follow the socio-economic and cultural modernisation of society, as otherwise it will be capable of achieving only limited success.⁸⁸ He emphasised the political difficulty of implementing a birth control policy at a time when economic priority lay in industrial development. He believed that industrialisation was the need of the hour for Sri Lanka in the 1950s, so he advocated the achievement of the targets of a population policy as a by-product of industrialisation. Thus, his suggestion was to 'draw up the plan of industrialisation in such a way that those forces which lead to a decline in fertility are obtained as a by-product'.⁸⁹ Having said that, he did not indicate how such a plan should be drawn up. Given the traditional socio-cultural context, Sarkar saw the introduction of a population policy as an outright blow to the power of any political party in post-independence Sri Lanka; it was just not the right time in the 1950s.

Taking numerous reports compiled by international experts on various aspects of the public health system of Ceylon into consideration, the assistant secretary of the Ministry of Health in 1956, Dr David Montague de Silva, suggested designing a population policy that could address the 'need for planning of additional employment, social services, housing, food and recreational facilities'.⁹⁰ His idea of a population policy was to strike a balance between resources and the population growth rate.

Writing about family planning in Ceylon in the late 1960s, Abhayaratne and Jayewardene considered the restrictions placed by the Ceylon government on indentured labour migration from south India to Sri Lanka in the late 1950s as a form of population policy.⁹¹

The aforementioned viewpoints and interpretations provide us with a window into the mentality of policymakers and academics of 1950s' Ceylon. Population was treated merely as a quantifiable object which could and should be controlled, manipulated and planned. Since the economic development priority of the 1950s lay in industrialisation, the designing of a population policy seemed a waste of energy and resources. Though the population was growing at the rate of 2.8 per cent in the late 1950s,

its impact was not consciously felt by the government until the mid-1960s, when it was faced with an increasing unemployment and under-employment problem.⁹² Due to the Swabhasha policy (Official Language Act or Sinhalese Only Act of 1956), a large section of the population—popularly known as the ‘children of 56’—was entering the work force with secondary or tertiary education without English-language proficiency, which was crucial for competing in the labour market, especially for white-collar jobs.⁹³ In 1965, through a cabinet decision, the Sri Lankan government accepted family planning as a national policy and brought it under the purview of the department of maternal and child health. This was the first measure taken by the state towards a population policy in Sri Lanka. In 1968, the Family Health Bureau (FHB) was set up at the Ministry of Health, which became the catalyst in implementing the government family planning programme.

The 1960s: Experimental Mode

Despite being involved in formulating the *Ten Year Plan* in 1959, Myrdal said in retrospect that the *Ten Year Plan* had ‘high qualities as an intellectual exercise, but nobody took it seriously, least of all the government.’⁹⁴ However, some attribute the government’s lack of enthusiasm towards implementing the *Ten Year Plan* to the loss of leadership incurred after the sudden demise of Prime Minister Bandaranaike in 1959 and the subsequent mismatch between the interests of the masses and the politicians.⁹⁵ However, post-independence development plans had a unique national and emotional connotation for both the policymakers and the people. Unfortunately, it was Sinhalese Buddhist nationalism that was implied in the plans as opposed to a wider Sri Lankan nationalism. Each government claimed their achievements through development plans, and the opposition political parties used those plans as the tools to criticise government policies when they failed to achieve their targets. Eventually, the *Ten Year Plan* remained a mere piece of academic excellence, which was never implemented. After S. W. R. D. Bandaranaike was assassinated, in 1962, his wife Sirima Bandaranaike took over the government and adopted a system of ‘rolling plans,’ making planning a continuous process rather than being limited to a fixed plan running through a long period.⁹⁶

Mrs Bandaranaike's development plan was called *The Short-Term Implementation Programme* of 1962. It had described the *Ten Year Plan* as a 'perspective plan' or a kind of preparatory work.⁹⁷ However, I see *The Short-Term Implementation Programme* as an extension of the *Ten Year Plan*, in the way it has dealt with the population problem. By the early 1960s, the focus of national planning was two-fold: to reduce population growth and to increase the use of resources.⁹⁸ Keeping in line with the global family planning programme, Mrs Bandaranaike decided to integrate family planning with the Maternal and Child Health (MCH) programme, and directed the department of health services to arrange to further educate the public on family planning practices, particularly in rural and estate areas.⁹⁹ Thus, Sri Lanka accepted family planning as a national policy in 1965, and the FHB was set up in 1968 within the Ministry of Health to carry out family planning activities.¹⁰⁰ With the integration of family planning and the MCH programme, the troubled population issue officially tied the knot with women's—or rather mothers'—health. Thus, the boundary between family planning and population control became rather fuzzy within official rhetoric because the objective of both these initiatives converged to curb the population growth rate. This in turn confused policymakers in the 1960s in distinguishing between a family planning programme and a population policy. Further, by integrating family planning with the MCH programme, the population growth rate was successfully reduced without the formulation of an actual population policy.

The 1970s: Implementation Mode

This confusion was further emphasised in *The Five Year Plan* of 1972–76 because family planning activities carried out by the FHB were mentioned under the sub-heading of 'Population Policy'.¹⁰¹ But when the government signed an agreement with the UNFPA in 1973 for 11 projects covering diverse areas of the population problem over a period of four years, population policy in Sri Lanka gained an all-encompassing meaning.¹⁰² As part of the UNFPA project, a national policy on family planning was declared by the Government of Sri Lanka.¹⁰³ Under this agreement,

UNICEF, WHO, UNESCO and ILO assisted the Government to execute this programme, which dealt with a number of Ministries such as Ministry of

Health, Justice, Education, Labour and Colombo Group of Hospitals. Population programmes were conducted also with the Janatha Estate Development Board, the State Plantations Corporation and Non-Governmental Organisations such as the FPA of Sri Lanka, Community Development Services, Population Services Sri Lanka and Sri Lanka Association for Voluntary Surgical Contraception.¹⁰⁴

With these initiatives, the subject of population expanded into other fields apart from health, and was integrated as a core concept within the country's development project. In this way, population became the 'problem' of all the aforementioned ministries, and they all tried to tackle the problem within their purview. In view of this, a steering committee was set up in 1972 to coordinate and monitor the implementation of all the population programmes that the project hoped to implement.

The meaning of policy changes over time. Of course, it would be an overambitious venture to try to find a population policy in the modern sense within the planning discourse of post-independence Sri Lanka. From a historiographical viewpoint, it is only possible to chart the varying meanings of population policy, as interpreted by different people. Likewise, population policy had diverse meanings and connotations at different historical moments within the development discourse. As I have mentioned earlier, population policy formulation was not a linear process, but reacted to different development priorities and internal (ethnic, social and religious) issues that sprung up over the years, such as the youth uprising in 1971 and 1987, and the ethnic conflict in 1983. Surprisingly, despite these upheavals, Sri Lanka upheld its development model status, especially with regard to women's health, well into the 1990s.

I will provide a brief political history of post-1977 Sri Lanka to understand the distinct turn that took place in the trajectory of women's health in the 1990s.

Post-1977: Open Economic Policy

Sri Lanka underwent a radical change in 1977 with the introduction of the open economic policy and a regime change from the socialist Sri Lanka Freedom Party (SLFP) to the capitalist United National Party (UNP). J. R. Jayawardena was elected as president with an overwhelming majority. Therefore, from 1977 to 1994, the UNP had an unprecedented

ability to influence the framing and implementation of state policy. With this regime change, Sri Lanka departed radically from the state-regulated, social welfare-oriented and inward-looking policies that characterised many post-colonial regimes. This radical departure meant policies of economic liberalisation with the goal of an increased economic growth.¹⁰⁵ Proclaiming his decision to 'let the robber barons in', President Jayawardena (1977–88) collaborated with the International Monetary Fund (IMF), the World Bank and Western governments to introduce structural adjustment policies (SAPs).¹⁰⁶ As Gunasinghe has written,

[i]n 1977, with the introduction of the open economic policy, most of the elements of the regulative mechanisms were dismantled. The system of quotas, permits, and licenses was abolished. The import-export trade was liberalized. ... The free health scheme was subverted, with doctors in government hospitals being granted the right to engage in private practice. The free education scheme was affected by teachers in the government schools being permitted to give private tuition.¹⁰⁷

The main stated aim of the SAPs was to make the economies of developing countries more market-oriented by concentrating more on trade and production in order to boost their economies.¹⁰⁸ These policy reforms (also referred to as neoliberal initiatives) advocated by the World Bank and the IMF were introduced to Sri Lanka in 1989 by the ruling UNP and were continued by the Peoples' Alliance (PA) government elected in 1994.¹⁰⁹ The second wave of SAPs in the 1990s reorganised conventional welfare by promoting 'privatisation of the public sector and liberalisation of the economy', which in turn affected the state's long-held patriarchal image as the 'provider' for its citizens.¹¹⁰ For this, some criticised the state for not keeping citizens' welfare in focus.

However, this new liberal policy environment attracted the investment of large multinational companies in Sri Lanka.¹¹¹ Adhering to the Women in Development (WID) approach that characterised many development initiatives of the early 1970s, women were integrated into development projects. The Sri Lankan government conceptualised the opening of the export processing zone/free trade zone in Katunayake as part of the national economic plan to make use of female labour spread across rural areas. By recruiting women to work in export processing zones, especially

in garment factories, and providing domestic labour to the oil-rich Middle Eastern countries through female migrant workers, Sri Lanka adopted the WID approach. With the open economy, women's labour became the backbone of the foreign income structure in Sri Lanka. By 1986, Sri Lanka's share of industrial exports overtook agricultural exports due to the growth in the garment industry.¹¹² By 1992, Sri Lanka's garment industry had overtaken tea exports to become the largest foreign exchange earner in the country (US\$ 400 million).¹¹³ The international media soon dubbed Sri Lanka 'the new investment centre of Asia.'¹¹⁴

With the implementation of these dynamic development projects, people lost faith and confidence in planning and policymaking by the late 1970s. According to the newspapers of the day, planning seemed purely an academic venture. An article in *The Ceylon Daily News* criticised the planning process as a waste of time and resources, and suggested a programme of action instead. The article also stated, 'Planning was not writing books. As far as Sri Lanka was concerned that had been the case. The plans had become like theses for post-graduate qualifications.'¹¹⁵

The cartoon in Image 1.1, published in one of the well-distributed English dailies of Sri Lanka, is a classic example of the weariness with development planning after almost three decades of futile planning.¹¹⁶ After 1977 came a new, dynamic era which emphasised implementation and action, rather than planning and theorising. Comprehensive policy was not needed, but policy measures which could be implemented directly and effectively were regarded as the need of the hour. The secretary to the Ministry of Plan Implementation in the late 1970s attested to this when I interviewed him on the history of population policy formulation in Sri Lanka. He said that during his tenure (1977–87), he never genuinely wanted to formulate a population policy. In fact, he saw it as a waste of time and resources; instead, he believed in the actual act of implementing. He also questioned me (in a rather cynical manner) on the use of a policy document.

No. I never believed in policy documents, because if I have come up with one, university academics and legal people [would] try and find loopholes in it and criticise that; nothing will happen in real terms. Policymaking is a real waste of time and also the worst thing to do as an administrator. My approach was to

do daring things, so I concentrated on implementation and I had a wonderful staff, really committed, and I had the backing of the executive president so I did what I thought was right and appropriate. Have you heard of Macaulay's words, 'For Forms of Government let fools contest; whatever is best administered is best'; that was my policy and that is what I believe.¹¹⁷

He further stated that

[I] amended the government gazette, bringing more subjects under my ministry—one being 'the formulation and implementation of population policy'. This one sentence was the key to all I thereafter did in the field. It was like a magic wand. With that one sentence no one doubted what our ministry did or could do or our authority to do it.¹¹⁸

Even though he was not genuinely interested in formulating a population policy, he used that one particular sentence that he added to the government gazette to implement population policy measures such as sterilisation incentives, putting family planning above party politics, establishing the population division and PIC at the Ministry of Plan Implementation, the funding of social marketing programmes for contraceptives and getting Ayurvedic practitioners trained and involved in family planning.¹¹⁹ The post-1977 era was a period of dynamically implemented projects and programmes aimed at achieving 'development', in which population control was one of the main components.

In any case, this dynamic implementation mode was not without its shortcomings. Initially, family planning was the responsibility of the Ministry of Health and was implemented by the FHB; but by the 1980s, because of the UNFPA initiative, population was no longer the responsibility of any ministry. Instead, it had become the responsibility of all the aforementioned ministries.¹²⁰ Thus, by the mid-1980s, there appeared a rift between the Ministry of Health and the Ministry of Plan Implementation regarding whose purview family planning should come under. The Ministry of Health claimed that family planning was traditionally a matter of medical expertise, and intervention by the Ministry of Plan Implementation should be limited to 'non-medical, non-health population matters'.¹²¹ However, the secretary of the Ministry of Plan Implementation in the late 1970s sees the intrusion of the

Ministry of Health into the field of population and family planning as a coup against him. Keeping in mind the broader picture of Sri Lanka's development plan implementation, I see this not as a rift, but as the strengthening of the link between women's health, population and development. Due to the mode of dynamic implementation undertaken by the state, population had to be carefully planned. Population became a women's health concern as well as a development concern. However, the outcome was a diminishing of the possibility of developing a comprehensive approach to women's health. Women's ability to reproduce became a problem for the state and as a consequence, reproduction became synonymous with women's health.

At this point, it is necessary to provide a brief account of the economic, political and governmental context of 1990s' Sri Lanka to understand the disconnect (which I will discuss in Chapters 4 and 5) that emerged between the way the state framed the discourse on the woman's body and the international women's health agenda in the 1990s.

The 1990s: The Turbulent Decade

Although the UN General Assembly proclaimed the 1990s as the 'Fourth United Nations Development Decade', for Sri Lanka the 1990s was a decade of economic and political turbulence. In the 1990s, the Sri Lankan state faced three major challenges. The first came in the form of an economic crisis with the onslaught of the second phase of SAPs in 1989. The second came as military challenges in the form of the Janatha Vimukthi Peramuna (JVP, People's Liberation Movement) uprising (1987–91) in the south and the violent ethnic conflict with Tamil separatists (1983–2009) in the north and east of Sri Lanka. The third came in the form of political challenges when the PA overthrew the 17-year rule of the UNP (1977–94).

ECONOMIC, MILITARY AND POLITICAL MILIEU OF THE 1990s

Despite the criticism it elicited, the liberalisation exercise continued with the second phase of SAPs with the blessing of President Ranasinghe Premadasa, who was elected by the UNP in 1989. This was largely

accomplished by strategically deploying women's labour.¹²² Contrary to expectations, the budget deficit increased to 7.5 per cent of the gross domestic product (GDP) in the 1990s due to escalating defence expenditures and non-bank borrowings. This situation worsened further when Sri Lanka's private sector lobbied for tax concessions. This pushed the state to come up with ad hoc policymaking, which in the end led to allegations of cronyism.¹²³

In 1994, the PA came to power with Chandrika Kumaratunge as president, aided by the election slogan, 'Market policy with a human face'. The new government broadly continued policies of liberalisation. The PA introduced several big service-oriented ventures, privatising the gas, telecom and airline services.¹²⁴

During the rule of both the UNP and the PA, liberalisation of the economy continued with the setting up of 200 rural garment factories, and encouraging women to seek employment in the Gulf countries as housemaids. Yet, the state mobilised women's labour without emancipating them from the patriarchal structure or empowering them to challenge it themselves. Instead, the state strategically used longstanding, widespread ideas of Sri Lankan Sinhalese womanhood, such as the feminine qualities of nimble fingers and docile, disciplined bodies. In other words, the state deployed women's bodies, keeping them within their traditional roles to fill its own coffers.

Broadly speaking, until the 1990s, the international development and population control agenda and women's health agenda of Sri Lanka were, while not identical, certainly mutually intelligible. However, by the mid-1990s, a tension could be seen to be developing between achieving demographic targets (replacement-level fertility) and the need for the militarised Sri Lankan state to access women's bodies for political and economic ends. According to renowned demographers Langford and de Silva, by 1994, Sri Lanka reached replacement-level fertility six years ahead of the target predicted by the UN's medium variant population projections prepared in 1990.¹²⁵ This means, in demographic parlance, that by 1994, Sri Lanka was ready to shift from a 'controlled and planned' women's health ideology to the reproductive health and rights paradigm proposed at the International Conference on Population and Development (ICPD) in 1994, though this never materialised.

In the 1990s, the Sri Lankan state mobilised the discourse on the woman's body embedded in traditional socio-cultural reproductive roles to cater to the economic and political commitments of the state, fashioned by the second phase of SAPs and the militarisation of ethnic conflict. The state's deployment of the discourse on the woman's body did not make space for the shift to the reproductive health and rights paradigm in the sphere of women's health. When the ICPD agenda proposed to look at women's health 'beyond reproduction' by advocating reproductive health and rights, the state continued to frame the discourse on the woman's body within a social reproductive role as nurturers of the community and nation and disseminators of tradition and culture in order to face the turbulent political situation of the 1990s. Due to this conflict of interest, it seemed that the state was not ready to accommodate the new ideology of women's health 'beyond reproduction' through the island-wide Well Woman Clinic (WWC) programme in 1996.

WOMEN'S HEALTH IN OFFICIAL RHETORIC

From the very beginning in the 1950s, women's health came under the maternal and child health section of development plans. This implies that women were seen only as mothers whose main responsibility was to give birth to healthy children who could shoulder the development programmes of the country. Women were idealised as mothers of the nation-state, and their prime duty was designated as social and biological reproduction. In agreement with this, S. Jayaweera and T. Sanmugam pointed out in 1995 that

[h]ealth and nutrition programmes have focused hitherto on the woman as a mother, in her reproductive role and as the care giver in the household. It is necessary that the entire life cycle of the woman be considered without respect to marital status. The mother and child syndrome has to be replaced by a holistic approach that includes the multiple roles of women and the health and nutritional needs of the adolescent girl, the single woman, the childless mother, the working woman and the ageing woman, especially as women in Sri Lanka are projected to live longer than men the lacunae in the provision of services to these categories need to be addressed.¹²⁶

In addition, in the early 1970s, a new term, 'family health', was introduced, which addressed the need to inculcate knowledge on nutrition, immunisation, health education, environmental health and family planning.¹²⁷ Moreover, by 1981, the population growth rate had come down to 1.7 per cent per annum; thus, population was not seen as a 'problem' anymore within official rhetoric.¹²⁸ After this, the dynamic secretary of the Ministry of Plan Implementation resigned from his post in 1987, and the vigour of programme implementation ebbed.¹²⁹

In contrast to the population control measures taken in response to the view of population as a grave problem in the 1970s, by the 1990s, the international arena advocated a new women's health concept. Instead of simply providing knowledge, medical and technical assistance and subtle coercion for population control, Sri Lanka formulated the Population and Reproductive Health Policy in 1998 as a consequence of the ICPD held in Cairo in 1994. The government WWC programme was launched in 1996 to screen women for common non-communicable diseases. The WWC programme suggested a shift in the way women's health was looked at: from 'controlling and planning' to a more comprehensive approach.¹³⁰

While I consider this shift laudable for its innovative approach, population policy measures are silent about women's bodies and reproductive rights. Through all these measures, population underwent a scrutinised surveillance process. In effect, the surveillance process was carried out through women's bodies because these policy measures ensured the careful 'controlling and planning' of women's reproduction in order to service the state-building project of independent Sri Lanka.

Chapter 2 charts the institutional history of family planning in Sri Lanka. It tells the overlapping stories of early family planning efforts in the 1930s, the beginnings of the FPA in the 1950s, the global politics of funding family planning programmes in the 1960s, and the Sri Lankan state's embrace of family planning and international funding in the 1970s and 1980s. In doing so, Chapter 2 shows how the ideology of population control replaced the maternalist welfare ideology in Sri Lanka by the 1970s and became the official ideology on women's health by the 1980s.

NOTES

1. Kirk, 'Nativity in the Developing Countries'; Caldwell et al., 'Is Marriage Delay a Multiphasic Response'; and Myrdal, *Asian Drama*, Vol. I, 1968.
2. Agreeing with Akhil Gupta, I do not simply mean a geographical space by the terms 'First World' or the 'West', but the concept that is determined by space, power and knowledge. In the same sense, I use the term 'Third World' not as a geographical entity but as a historical construct. See Gupta, 'Agrarian Populism in the Development of a Modern Nation (India)', in *International Development and the Social Sciences: Essays on the History and Politics of Knowledge*, eds F. Cooper and R. Packard, Berkeley/Los Angeles/London, University of California Press, 1997, pp. 320–44.
3. K. M. de Silva, "'The Model Colony': Reflections on the Transfer of Power in Sri Lanka', in *The States of South Asia; Problems of National Integration*, eds A. J. Wilson and D. Dalton, London, C. Hurst & Company, 1982, p. 83.
4. I. Taeuber, 'Ceylon as a Demographic Laboratory: Preface to Analysis', *Population Index* 15 (4), 1949, p. 303. The idea that Ceylon has kept a sound record of census statistics was the firm belief of K. Davis, 'Statistical Perspective on Marriage and Divorce', *The ANNALS of the American Academy of Political and Social Science*, 272 (1), 1950, pp. 9–21. Both Taeuber and Davies were members of the Office of Population Research at Princeton, USA. Frederiksen praised Ceylon for having a sound public health system to implement a malaria eradication programme that lowered the death rates of the country; see H. Frederiksen, 'Determinants and Consequences of Mortality Trends in Ceylon', *Public Health Reports* 76 (8), 1961, pp. 659–63.
5. Myrdal, *Asian Drama*, Vol. III, p. 1569.
6. Ibid.
7. Marga Institute, *Welfare and Growth; A Case Study of Sri Lanka Prepared for the UNRISD Project: The Unified Approach to Development Planning and Analysis*, Colombo, Marga Institute, 1974, p. 4.
8. P. Newman, 'Malaria and Mortality', *Journal of the American Statistical Association* 72 (358), 1977, p. 257; O. E. R. Abhayaratne, 'The Influence of Malaria on Infant Mortality in Ceylon', *Ceylon Journal of Medical Science* 7, 1950, pp. 33–54; H. Cullumbine, 'An Analysis of the Vital Statistics of Ceylon', *Ceylon Journal of Medical Science* 7, 1950, pp. 91–272; G. Macdonald, 'Community Aspects of Immunity to Malaria', *British Medical Bulletin* 8 (1), 1951, pp. 33–36; K. Davis, 'Statistical Perspective on Marriage and Divorce', *The ANNALS of the American Academy of Political and Social Science* 272 (1), 1950, pp. 9–21. H. Frederiksen, 'Determinants and Consequences of

- Mortality Trends in Ceylon', *Public Health Reports* 76 (8), 1961, pp. 659–63; P. Newman, *Malaria Eradication and Population Growth: With Special Reference to Ceylon and British Guiana*, Research Series No. 10, Bureau of Public Health Economics, School of Public Health, Ann Arbor, University of Michigan, 1965, and 'Malaria Control and Population Growth', *Journal of Development Studies* 6 (2), 1970, pp. 133–58; G. Jones and S. Selvaratnam, *Population and Economic Development in Ceylon*, Colombo, Marga Institute, 1972; R. H. Gray, 'The Decline of Mortality in Ceylon and the Demographic Effects of Malaria Control', *Population Studies* 28 (2), 1974, pp. 205–29.
9. Hartmann provides a very insightful analysis of the Malthusian theory of overpopulation creating a scarcity of resources in her seminal work, *Reproductive Rights and Wrongs, The Global Politics of Population Control* (revised edn), Boston, South End Press, 1995.
 10. The Population Association of America (PAA) was an offshoot of the American National Committee of the International Union for the Scientific Study of Population (IUSSP) formed in 1927 with biologist Raymond Pearl of Johns Hopkins University.
 11. 'Outcomes on Population', available at <http://www.un.org/en/development/devagenda/population.shtml> (accessed on 23 July 2024).
 12. Greenhalgh, 'The Social Construction of Population Science', p. 43.
 13. Hartmann, *Reproductive Rights and Wrongs*, pp. 4 and 104.
 14. *Ibid.*, p. 4.
 15. Jones and Selvaratnam, *Population and Economic Development in Ceylon*, p. 20.
 16. Corea, 'Ceylon in the Sixties', p. 2; W. D. Lakshman and C. A. Tisdell, *Sri Lanka's Development since Independence*.
 17. Lakshman and Tisdell, 'Introduction to Sri Lanka's Development', p. 9.
 18. In the academic year of 1972/73, a US\$ 6 million multidisciplinary population programme was launched by the UNFPA in Sri Lanka, and the Demographic Training and Research Unit (DTRU) was one of them. But the DTRU did not directly deal with family planning programmes. See Ministry of Plan Implementation, *Population and Family Planning Activities in Sri Lanka*, Colombo, Population Division, Ministry of Plan Implementation, 1979, p. 26.
 19. *Population Problems of Sri Lanka (Proceedings of a Seminar)*, Colombo, Demographic Training and Research Unit, University of Colombo, 1976, p. v.
 20. *Ibid.*, p. vii.
 21. J. Caldwell, K. H. W. Gaminiratne, P. Caldwell, S. de Silva, B. Caldwell, N. Weeraratne and P. Silva, 'Is Marriage Delay a Multiphasic Response', p. 337.

22. N. K. Sarkar, 'Population Trends and Population Policy in Ceylon,' *Population Studies* 9 (3), 1956, p. 195. In his book *Demography of Ceylon*, Colombo, Ceylon Government Press, 1957, he gives an account of descriptive assumptions on the size of the population made by colonial administrators such as Tennent (1859) and Forbes (1840), based on the ancient ruins of kingdoms, irrigation systems and chronicles (Mahavamsa), which later census superintendents such as Denham (1911) and Turner (1921) refuted (pp. 6–12).
23. *Six Year Programme of Investment 1954/55 to 1959/60*, Colombo, Planning Secretariat, Government of Ceylon, 1954, p. 377.
24. Kirk, 'Natality in the Developing Countries', p. 80.
25. Caldwell et al., 'Is Marriage Delay a Multiphasic Response', p. 338. See also W. I. de Silva, 'The Ireland of Asia: The Trends in Marriage Timing in Sri Lanka', *Asia-Pacific Population Journal* 12 (2), 1997, p. 3.
26. N. H. Wright, 'Recent Fertility Change and Prospects for the National Family Planning Programme', *Demography* 5 (2), 1968, pp. 745–56; D. F. S. Fernando, 'Recent Fertility Decline in Ceylon', *Population Studies* 26 (3), 1972, pp. 445–53; and J. Caldwell, K. H. W. Gaminiratne, et al., 'The Traditional Fertility Regulation in Sri Lanka', *Studies in Family Planning* 18 (1), 1987, 1–21.
27. Stated in W. I. de Silva, 'Age at Marriage in Sri Lanka: Stabilising or Declining?' *Journal of Biosocial Science* 22 (4), 1990, p. 395. Also see D. F. S. Fernando, 'Fertility Trends in Sri Lanka and Future Prospects', *Journal of Biosocial Science* 8 (1), 1976, pp. 35–43; Wright, 'Recent Fertility Change'; N. H. Wright, 'Ceylon: The Relationship of Demographic Factors and Marital Fertility to the Recent Fertility Decline', *Studies in Family Planning* 59, 1970, pp. 17–20; D. P. Smith, 'Illustrative Analysis: Marriage Dissolution and Remarriage in Sri Lanka and Thailand', *World Fertility Survey Scientific Report No. 17*, Voorburg, International Statistical Institute, 1980; J. Trussell, 'Illustrative Analysis: Age at First Marriage in Sri Lanka and Thailand', *World Fertility Survey Scientific Report No. 13*, Voorburg: International Statistical Institute, 1980; G. Immerwahr, 'Contraceptive Use in Sri Lanka', *World Fertility Survey Scientific Report No. 18*, Voorburg, International Statistical Institute, 1981; C. M. Langford, 'Fertility Change in Sri Lanka since the War: An Analysis of the Experience of Different Districts', *Population Studies* 35 (2), 1981, pp. 285–306; J. McCarthy, 'Differentials in Age at First Marriage', *World Fertility Survey Comparative Studies: Cross-National Summary No. 19*, Voorburg, International Statistical Institute, 1982; P. G. Smith, M. Shahidullah and A. N. Alcantara, 'Cohort Nuptiality in Asia and the Pacific: An Analysis of WFS Surveys', *World Fertility Survey Comparative Studies No. 22*, Voorburg, International Statistical Institute, 1983—all cited in de

- Silva, 'Age at Marriage in Sri Lanka.' Also see Caldwell et al., 'The Traditional Fertility Regulation'.
28. de Silva, 'Age at Marriage in Sri Lanka', p. 403.
 29. Jones and Selvaratnam, *Population and Economic Development in Ceylon*, p. ii.
 30. Ibid.
 31. S. L. N. Rao, 'Mortality and Morbidity in Sri Lanka', *Population Problems of Sri Lanka (Proceedings of a Seminar)*, Colombo, Demographic Training and Research Unit, University of Colombo, 1976, p. 27.
 32. Lakshman and Tisdell (eds), *Sri Lanka's Development since Independence*, p. 5.
 33. C. M. Langford, 'Fertility Decline in Sri Lanka: Could Fertility Now Be at about Replacement Level?' in *Fertility Transition in South Asia*, eds Z. Satha and J. Phillips, Oxford, Oxford University Press, 2001, p. 131.
 34. According to the established assumption, the first step towards development is to reduce the population growth rate to replacement-level fertility.
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 36. Interview with the former medical director of the Family Planning Association (FPA) on 16 February 2010 at her residence in Colombo.
 37. Marga Institute, *Welfare and Growth*, p. 43.
 38. Ibid.
 39. B. Zachariah, *Developing India; Intellectual and Social History c. 1930–1959*, Oxford/New York/New Delhi, Oxford University Press, 2005, p. 7.
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 41. Quoted in S. Chinnatamby, *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, 1969, p. 33.
 42. Myrdal, *Asian Drama, Vol. II*, p. 728.
 43. M. Rahnema, 'Towards Post-Development: Searching for Signposts, a New Language and New Paradigms', in *The Post-Development Reader*, eds Rahnema and Bawtree, p. 392.
 44. Myrdal, *Asian Drama, Vol. II*, p. 722.
 45. Chatterjee, *The Nation and Its Fragments*, p. 202.
 46. Ibid., p. 200.
 47. Marga Institute, *Welfare and Growth*, p. 44.

48. See D. M. de Silva, *Health Progress in Ceylon: A Survey*, Colombo, Ministry of Health, Ceylon, 1956, pp. 6–10. Amongst them were Dr J. H. L. Cumpston (former director general of Health Services of the Commonwealth of Australia), mandated to report on the working of the medical and public health system of Ceylon, and to advise the government on improving and reforming the system; Dr Abraham Stone from the WHO to report on population control and family planning; Donald Barlow, the eminent British thoracic surgeon who visited Ceylon to advise on thoracic services; Sir Sydney Caine, who paid a visit as the chief of mission of the International Bank for Reconstruction and Development (IBRD); R. N. Clarke of the WHO, who visited Ceylon to advise on public health engineering; and Professor Abel Wolman of the WHO, who came down to advise on managing water resources.
49. *International Assistance for Education for Development; The Colombo Plan Special Topic Report*, considered by the 20th Consultative Committee Meeting held in Manila, February 1971, pp. 74–75.
50. *Ibid.*, p. 75.
51. For a comprehensive analysis of the nationalist movement and sentiments in pre-independence Ceylon, see A. J. Wilson, *Sri Lankan Tamil Nationalism: Its Origins and Developments in the Nineteenth and Twentieth Centuries* (second edn), University of British Columbia, 2000; K. M. de Silva (ed.), *Sri Lanka; A Survey*, London, C. Hurst & Co., 1977; P. Jeganathan and Q. Ismail (eds), *Unmaking the Nation: The Politics of Identity and history in Modern Sri Lanka*, Colombo, Social Scientists' Association, 1995; and J. Uyangoda, 'Social Conflict, Radical Resistance and Projects of State Power in Southern Sri Lanka: The Case of the JVP', in *Building Local Capacities for Peace; Rethinking Conflict and Development in Sri Lanka*, eds M. Mayer, D. Rajasingham-Senanayake and Y. Thangarajah, New Delhi, Macmillan India, 2003.
52. W. D. Mignolo, 'Epistemic Disobedience, Independent Thought and Decolonial Freedom', *Theory, Culture & Society* 26 (7–8), 2009, pp. 160–61.
53. *The Short-Term Implementation Programme and Drafts*, Colombo, Ministry of National Planning, 1962, p. 42.
54. M. Foucault, *The Will to Knowledge: The History of Sexuality*, Vol. 1, tr. R. Hurley, London, Penguin Books, reprint, 1998, p. 25.
55. Scott, *Seeing Like a State*, p. 71.
56. *Ibid.*, pp. 25–33, for a very illustrative analysis of the politics of measurement in relation to state-building and statecraft. See also Scott on census reports as state projects of legibility and standardisation, pp. 64–71.
57. *Census of Island of Ceylon 1871, General Report*, compiled by G. S. Williams, Colombo, Government Printer, Ceylon, 1873, p. ix.

58. Ibid. p. xv.
59. W. I. de Silva, 'Population Planning Strategies and Programmes in Sri Lanka', *Asian Profile* 23 (5), 1995, p. 404.
60. *Census of Ceylon 1891: A General Report, Volume I*, compiled by Lionel Lee (Ceylon Civil Service, Superintendent of Census), Colombo, Ceylon Government Printer, 1892, p. 11.
61. *Ceylon Census of 1911, The Review of the Results of the Census of 1911*, E. B. Denham, Colombo, Ceylon Government Printer, 1912, p. 12.
62. Ibid.
63. *Census Publications, Ceylon 1921, Report on the Census of Ceylon, 1921*, Vol. 1, Part I, L. J. B. Turner (Superintendent of Census and Director of Statistics, Ceylon), Colombo, Ceylon Government Printer, 1923, p. 18.
64. Ibid., p. 24.
65. *Census of Ceylon 1946, Vol. 1, Part 1, General Report*, A. G. Ranasinha, Colombo, Ceylon Government Press, 1950, p. 67.
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67. Ibid., p. 60.
68. Ibid., p. 70.
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72. S. Colombage and S. A. Karunaratne, 'Development Planning and Investment', in *Facets of Development in Independent Sri Lanka, Ronnie de Mel Felicitation Volume*, eds W. Rasaputra, W. M. Tilakaratne, S. T. G. Fernando and L. E. N. Fernando, Colombo, Lake House Printers, 1986, p. 197. See also Marga Institute, *Welfare and Growth*, p. 43, for a description of the Six Year Programme of Investment as an ad hoc exercise.
73. 'The Colombo Plan', available at <http://www.colombo-plan.org/index.php/about-cps/history/> (accessed on 23 July 2024).
74. Sarkar, *Demography of Ceylon*, p. 256; and Colombage and Karunaratne, 'Development Planning and Investment', p. 197.
75. Sarkar, 'Population Trends and Population Policy', p. 209.
76. *Six Year Programme of Investment 1954/55 to 1959/60*, Colombo, Planning Secretariat, Government of Ceylon, 1955, p. v.
77. Ibid., p. 3.
78. Ibid., p. 404.
79. *Papers by Visiting Economists*, Colombo, Planning Secretariat, 1959, Preface.

80. *National Planning Council: The Ten Year Plan*, Colombo, Ceylon Government Press, 1959, p. 12.
81. *The Ten Year Plan*, Colombo, Ceylon Government Press, 1959, pp. 16–17.
82. *Ibid.*, p. 17.
83. *Ibid.*
84. Abhayaratne and Jayewardene, *Family Planning*, p. 15.
85. de Silva, 'Population Planning Strategies', p. 400.
86. *The Report of National Workshop on Population Information Exchange & Resource Development in Sri Lanka*, organised by the Population Information Centre (PIC), Ministry of Plan Implementation and ESCAP (*Economic and Social Commission for Asia and the Pacific*), with financial support from the UNFPA, held at Colombo, 10–12 December, 1980, Foreword.
87. Sarkar, 'Population Trends and Population Policy', p. 207.
88. Sarkar, *Demography of Ceylon*, p. 246.
89. Sarkar, 'Population Trends and Population Policy', p. 207.
90. de Silva, *Health Progress in Ceylon*, p. 14.
91. Abhayaratne and Jayewardene, *Family Planning*, p. 15.
92. Marga Institute, *Welfare and Growth*, p. 25.
93. For an analysis of the impact of the language policy on education in Sri Lanka, see N. Wickramasinghe, *Sri Lanka in the Modern Age: A History of Contested Identities*, London, Hurst and Company, 2006, p. 235; and C. R. de Silva, 'Education', in *Sri Lanka: A Survey*, ed. K. M. de Silva, London, C. Hurst & Co., 1977, p. 412.
94. Myrdal, *Asian Drama, Vol. I*, p. 358.
95. The masses were agitated over ethnic and religious issues and the politicians were interested in achieving broader goals of development.
96. Myrdal, *Asian Drama, Vol. I*, p. 358.
97. *The Short-Term Implementation Programme*, p. 39.
98. *Ibid.*, p. 17.
99. *Annual Report of the Family Planning Association 1969–70*, Colombo, FPA, 1970, pp. 4, 19.
100. de Silva, 'Population Planning Strategies', p. 400.
101. *The Five Year Plan, 1972–1976*, Colombo, Ministry of Planning and Employment, 1971, p. 121.
102. W. Weerasooria, 'Pre-ICPD Activities on Population and Development in Sri Lanka (1977–1987)', in *ICPD—'15 Years On' Sri Lanka*, ed. B. Weerakoon, Colombo, FPA, 2009, p. 1. I have mentioned the areas covered by these 11 projects in the Introduction.

103. Ministry of Plan Implementation, *Population and Family Planning Activities in Sri Lanka*, p. 26.
104. *Public Investment, 1986–1990*, Colombo, National Planning Division, Ministry of Finance and Planning, 1986, p. 130.
105. N. Gunasinghe suggests that the open economy drawn by export-led growth can be linked to the ethnic tensions which culminated in 1983. See N. Gunasinghe, 'The Open Economy & Its Impact on Ethnic Relations in Sri Lanka', in *Sri Lanka, the Ethnic Conflict: Myths, Realities and Perspectives*, Committee for Rational Development, New Delhi, Navrang, 1984, pp. 197–214.
106. N. DeVotta, 'Politics and Governance in Post-independence Sri Lanka', in *Routledge Handbook of South Asian Politics: India, Pakistan, Bangladesh, Sri Lanka and Nepal*, ed. P. R. Brass, London/New York, Routledge, 2010, p. 121.
107. N. Gunasinghe, 'The Open Economy and Its Impact on Ethnic Relations', in *Economy, Culture, and Civil War in Sri Lanka*, eds D. Winslow and M. Woost, Bloomington and Indianapolis, Indiana University Press, 2004, p. 101.
108. W. D. Lakshman, 'Introduction', in *Dilemmas of Development: Fifty Years of Economic Change in Sri Lanka*, ed. W. D. Lakshman, Colombo, Sri Lanka Association of Economists, 1997, p. 10.
109. Ibid.
110. K. Ruwanpura, *Structural Adjustment, Gender and Employment: The Sri Lankan Experience*, Geneva, ILO, 2000, p. 3.
111. The first export processing zone or free trade zone was set up in a complex of 500 acres adjacent to the Katunayake International Airport in 1978 in order to encourage export-led industrialisation, which attracted foreign direct investments and domestic entrepreneurs due to various tax concessions. See S. Kelegama, *Development Under Stress: Sri Lankan Economy in Transition*, Colombo, Institute of Policy Studies, 2006, p. 52; and *Public Investment, 1979–1983*, Colombo, Ministry of Finance and Planning, 1984, p. 56.
112. G. Gunatilake, 'Development Policy Regimes', in *Sri Lanka's Development Since Independence: Socio-economic Perspectives and Analysis*, eds W. D. Lakshman and C. A. Tisdell, New York, Nova Science Publishers, 2000, p. 147.
113. S. Kelegama, 'Ready-Made Garment Industry in Sri Lanka: Preparing to Face the Global Challenges', *Asia-Pacific Trade and Investment Review* 1 (1), 2005, p. 53; and W. D. Lakshman, 'Economic Development and Sociopolitical Change in Sri Lanka', in *Routledge Handbook of South Asian Politics*, p. 340.
114. Kelegama, *Development Under Stress*, p. 53.

115. 'Planning Ministry Bureaucrats under Fire', *The Ceylon Daily News*, 20 October 1977, p. 3.
116. S. C. Opatha, cartoon in the *Daily Mirror*, 21 August 1978, p. 4.
117. Interview with the retired secretary to the Ministry of Plan Implementation in the late 1970s, on 7 August 2011 at his office in Colombo. (The quote is from Alexander Pope, not Macaulay.)
118. Weerasooria, 'Pre-ICPD Activities on Population', p. 2.
119. *Ibid.*, p. 3.
120. *The Report of National Workshop on Population Information Exchange & Resource Development in Sri Lanka*, Colombo, p. 23.
121. Weerasooria, 'Pre-ICPD Activities on Population', p. 5.
122. According to Kelegama, Premadasa's economic policy was characterised by three main policy decisions: First, export-oriented industrialisation was further promoted by launching 200 rural garment factories. Second, he renamed privatisation as 'peopleisation', in the hope of gaining workers' support by conferring broad-based ownership to the public. Third, he launched the programme of *Janasaviya* (people's strength), a poverty alleviation programme that addressed the needs of the rural poor and the urban working class. Kelegama, *Development Under Stress*, pp. 59–62.
123. *Ibid.*
124. *Ibid.*, p. 56.
125. Langford, 'Fertility Decline in Sri Lanka', p. 131.
126. S. Jayaweera and T. Sanmugam, *Addressing Poverty Reduction and Women in Development through Human Resource Development*, Colombo, CENWOR, 1995, p. 67.
127. *Development 1931–1981 Sri Lanka*, Colombo, Ministry of Plan Implementation, 1981, p. 117.
128. *Public Investment 1981–1985*, Colombo, Ministry of Finance and Planning, 1981, p. 31.
129. Interview with the former director of the population division of the FHB, Colombo, 10 August 2011, at his new office in Colombo.
130. The Well Woman Clinic (WWC) programme and the population and reproductive health policy are analysed in greater detail in Chapter 5.

2

Population Control and Family Planning in Ceylon (1930s to 1980s)

INTRODUCTION

This chapter traces the career of family planning in Sri Lanka—from its pre-history of the fragmented birth control movement under colonialism to the re-branding of family planning as ‘reproductive health’ after the ICPD. Although the history of family planning in Sri Lanka resembles much of the careers of family planning programmes undertaken in other countries during the same period, it does have a number of aspects particular to itself. One such example is the distant relationship the state maintained with the concept of family planning until the mid-1960s (almost one-and-a-half decades after the Family Planning Association [FPA] was established).

As mentioned in Chapter 1, during the 1950s, Sri Lanka came under the ‘radar’ of the global population establishment as a social laboratory aiding global research on population and contraceptives.¹ By the 1970s, this ‘population laboratory’ had become a ‘development model’ for South Asia due to its decreased fertility and mortality levels, increasing life expectancy, high women’s literacy rate and sound public health services. The trajectory of the family planning programme of Sri Lanka both reflects and forms part of the project of family planning across the world during the twentieth century.

This chapter shows the career of such concepts as eugenics, birth control, population control, family planning and reproductive health

within the family planning programme of Sri Lanka.² Even though these terms have a distinct meaning within the global politics of population control, they have acquired different connotations in the context of the Sri Lankan family planning programme. The term 'population control' is used throughout, despite the worldwide shift in terminology from birth control to population control, and from family planning to reproductive health.³ During my fieldwork, it became obvious to me that demographers, medical/health professionals and policymakers of Sri Lanka did not and still do not make an attempt to take cognisance of this shift and its implications at the policymaking level. I argue that policymakers' uncritical and unstinted belief in a neo-Malthusian population control ideology made them disregard the logic of this shift in terminology. In fact, policymakers take these shifts for granted.

In contrast, eminent scholar Vandana Shiva, when studying the Indian context, claims that this terminology shift has not been an innocent process but is a political one with a capitalist agenda. She points out that although the contraceptives pushed through these programmes may not be safe for women, they are disguised by the empathetic notion of 'safe motherhood'.⁴ However, Sri Lanka has produced no such analytical work on women's health policies or issues. Even though this chapter focuses on the history of the family planning programme in Sri Lanka, it remains more or less an institutional history. Focusing on this terminology shift helps to understand how the family planning programme in Sri Lanka embedded itself in the global population studies establishment.

The first section of this chapter places Sri Lanka within the global population discourse. The second section explores the development of the family planning programme in Sri Lanka, how it was dealt with by the government and how it relates to the larger ethnic and political issues of the country. I describe how the state's 'planning ideology' in the late 1950s, 'experimental mode' of the 1960s and 'implementation mode' of the late 1970s affected the family planning programme. By doing so, I point out the vexed connection between women's health and the discourses on the woman's body in post-independence Sri Lanka.

A BRIEF HISTORY OF GLOBAL POPULATION CONTROL PROGRAMMES

Many historians, writing from Marxist, feminist and post-colonial traditions, perceive eugenics as the predecessor of population control, which 'changed its name and to some extent its clothes' after World War II.⁵ Eugenics, essentially about fertility regulation, and the two aspects of fertility—quality and quantity—were termed 'positive eugenics' and 'negative eugenics', respectively, in the early twentieth century.⁶ 'Positive eugenics' promoted procreation among desired population cohorts such as the middle class—educated and 'healthy groups'—to create and produce the perfect human being for the modern world. 'Positive eugenics' was promoted in the early twentieth century in response to two fears. The first was the fear of declining numbers in Europe (reduction of the best stock) and the second was of the increasing numbers of the colonised (proliferation of the bad stock). There was a rapid decline in the population growth rate from the 1880s in Europe, which was widely perceived as 'a key component of "degeneration"'.⁷ The corrective measure proposed by the West was negative eugenics. The target of 'negative eugenics' was the 'unfit', 'the poor', 'the colonized' and 'unpopular strangers'.⁸

According to negative eugenics, sterilisation was the solution to limit the growth of problem populations. This was a particularly popular method suggested to curb Asia's burgeoning population. Commentators on Margaret Sanger's Birth Control International Information Centre organised a conference on 'Birth Control in Asia' between 23 November and 25 November 1933 at the London School of Hygiene and Tropical Medicine. The aim of the conference was to discuss the 'economic and political problems created by pressure of excessive populations in Eastern territories'.⁹ These conferences helped, as mentioned in Chapter 1, to create the ideology of population control among the policymakers and academics of Asia, which was termed by Hartmann as 'conventional wisdom'.¹⁰ According to this ideology, 'the only way out for the poor is to stop being born', which was justified by the rich and powerful 'by a wave of a magic wand' called population control programmes.¹¹ By the 1930s, there were active birth control movements in at least 30 countries around the world.¹²

DR MARY RUTNAM AND EARLY EFFORTS OF FAMILY PLANNING IN SRI LANKA

The first documented, organised attempt at birth control in Sri Lanka started in 1937 when the Canadian-born Dr Mary Rutnam (nee Irwin) opened a birth control clinic in Sri Lanka's capital city, Colombo.¹³ She was inspired by fellow Canadian doctors C. Oliver and Margaret O'Hara, who were engaged in social reform and welfare activities in early twentieth-century India. The India-based Dr Oliver's visit to Colombo in 1904 persuaded Dr Rutnam to subscribe to British, American and Canadian journals to widen her knowledge about contemporary trends and developments in the West. This impacted her social work.¹⁴ Thus, the family planning programme in Sri Lanka, as elsewhere across the globe, started as a birth control clinic. The middle-class women of the colonised bourgeoisie copied the role of these white, imperial women. To put Rutnam's social work and other efforts at birth control, family planning and women's health in context, I will sketch the brief colonial history of Sri Lanka.

Sri Lanka was under Western colonial rule for nearly four centuries until independence was granted by the British in 1948. The Portuguese (1505–1656) and the Dutch (1656–1796) held only coastal areas, but the British ruled over the entire island from 1815 to 1948. By the 1900s, in order to facilitate the tea plantation economy, railways, roads and harbours were developed by the British government.¹⁵ Simultaneously, a new social consciousness developed among the colonised. Due to the tea plantation economy and increased educational facilities, an urban and a rural petty bourgeoisie class took shape by the late nineteenth century.¹⁶ Following India's lead, in 1919, the Ceylon National Congress was formed. Other mass social movements included the Social Service League, founded in 1915, that addressed health issues and promoted welfare thinking.¹⁷

Influenced by British, American and Canadian women's rights advocates, and taking the example of Indian women activists, a group of Sri Lankan middle-class, Western-educated women came together to fight for women's rights and social reform. The Women's Franchise Union was formed in 1927 by a group of Sri Lankan professional women, many of whom were wives of nationalist and labour party leaders. The

first meeting of the Women's Franchise Union was presided over by Lady Dias Bandaranaike (mother of S. W. R. D. Bandaranaike, Sri Lanka's prime minister from 1956 to 1959).¹⁸ These pioneering women, members of these social and political movements, were doctors, teachers and lawyers. As mentioned in the Introduction, Sri Lankan women had the opportunity to avail of school education provided by Baptist and Methodist missionaries at the American Mission and the Church Missionary Society from the 1820s. By the early 1900s, there were a significant number of qualified upper-class women in Sri Lanka, eager to engage in social work.

Such was the milieu when Dr Mary Rutnam started her social work in Colombo. Having failed to find employment at mission hospitals—despite being a qualified gynaecologist—because of her unconventional marriage to a Sri Lankan Tamil, Dr Rutnam took up a temporary job at the Lady Havelock Hospital for Women and Children in Colombo.¹⁹ Rutnam set up the Girls' Friendly Society in 1904 to create a space for young women where they could meet and discuss their problems. The Ceylon Women's Union was formed in the same year, and Rutnam used its venue to introduce local women to recent advances in maternal health, child care, nursing and education.²⁰ Rutnam addressed the issues of health and hygiene through her book, *A Health Manual for Schools* (1923), which was translated into Sinhalese and Tamil and used as a school textbook for several decades.²¹ Her untiring efforts to educate women in health and hygiene had the flavour of a 'civilising mission'. In the preface to the book *Homecraft Manual for Ceylon Schools* published in 1933, she wrote, 'Simplicity, orderliness, thrift and scrupulous cleanliness are the lessons that should be taught...for these are the essentials of good housekeeping in the homes of rich and poor.'²² Ideas and concepts of cleanliness, orderliness and thriftiness as the objectives of girls' education fitted well into the existing missionary education system of the colonies. Since 1927, Rutnam made clear her disappointment with government facilities for women, especially at the government maternity hospital in Colombo. By 1930, through social service activities, the Ceylon Women's Union had reached out to rural women, too, and changed its name to *Lanka Mahila Samiti* (Lanka Women's Society). In 1932, Rutnam was unsuccessful in her attempt to persuade the Ceylon Medical Council to include birth control and eugenics in the curriculum of the Ceylon Medical College.

In 1935, Edith How-Martyn, a close associate of Margaret Sanger, visited Colombo on her world tour for birth control. In 1937, following How-Martyn's lectures delivered in front of doctors and social workers, and after receiving a donation of £100 from a benefactor, Rutnam opened a birth control clinic in the Milk Feeding Centre of the Ceylon Social Services League in Colombo.²³ This supplemented the birth control advice she had already been providing to middle-class women at her nursing home on Havelock Road, in a well-to-do neighbourhood in Colombo.²⁴ The clinic functioned for two years until the events of World War II intervened and the colonial government took over. There were no further attempts to provide birth control advice to the general public until after World War II and the country's formal independence in 1948.

ESTABLISHING THE FAMILY PLANNING ASSOCIATION OF CEYLON – 1953

In 1952, Margaret Sanger, Dr Abraham Stone and Mrs Dorothy Brush visited Sri Lanka on their way back from the World Conference on Planned Parenthood in Bombay.²⁵ Their visit and support inspired women activists of Sri Lanka to establish the Family Planning Association (FPA) of Ceylon in 1953. At the inauguration of the FPA on 15 January 1953, in recognition of her efforts towards improving women's health in Sri Lanka, Dr Rutnam was appointed as the first president of the FPA (although she had retired from medical practice in 1944). The tea party that followed was attended by doctors, social workers and members of the All Ceylon Women's Conference (ACWC).²⁶ According to Mrs Sylvia Fernando, the hostess of the tea party and founding-secretary of the FPA was 'from the beginning...a relief to individuals—relief through contraception for overburdened incomes, overcrowded homes, malnourished children and physically exhausted mothers in slum and village.'²⁷

In other words, the FPA took up the project that had been interrupted by World War II, which seemed an important development need of independent Sri Lanka.

Fernando also came from a background of service to poor women. She was involved in social work through the ACWC and the Social Service League. In these organisations she helped poor and destitute

women improve their living conditions. Through the ACWC, she attended conferences abroad and had the opportunity to meet and listen to such pioneers of the American family planning movement as Margaret Sanger, Dorothy Brush, Dr Abraham Stone and Clarence Gamble.²⁸ Family planning as a social welfare venture was indeed new to Sri Lanka in the 1950s, though it goes without saying that Sri Lankan women had been attempting to control their fertility even earlier. Already in the 1940s, there were adverts about regulating reproduction, contraception and abortion in Sinhalese newspapers. Some of these adverts were placed by Ayurvedic physicians and some were simply marketed as help to 'women in need'.²⁹

When the first FPA family planning clinic was opened at the De Soysa Hospital for Women in Colombo in September 1953, it was aptly called the 'Mothers' Welfare Clinic'. Newspapers announced: 'A Mothers' Clinic will be held every Wednesday afternoon from 2–4.30 pm at the De Soysa Maternity Hospital where advice will be given to childless couples and on family planning.'³⁰ According to one of the founder-members of the FPA, Dr Aluvihare, the order of the words in this press release was decided after much deliberation so as to avoid inviting scorn by highlighting the main feature of the clinic, which was family planning.³¹ By February 1954, there were 300 clients on the roster of the family planning clinic at the De Soysa Maternity Hospital³² (de Silva 1979b, p. 21).

Another early FPA member pointed out that family planning was regarded as a 'dirty word' during the 1950s.³³ The elite founders of the FPA perceived family planning as helping the poor and destitute,³⁴ and their work could be best described as altruistic welfare. However, throughout the history of family planning in Sri Lanka, concepts such as eugenics, birth control and family planning were all intertwined rather than distinct in the programme. The boundaries of these concepts were, and still are, rather blurred. Social service was the best and most respectable avenue in the 1950s for upper-class women who wanted to step out of their domestic domain and enter the public sphere. Family planning provided an opportunity for well-educated women, who at the same time perceived it as a noble endeavour to help destitute women improve their life conditions. Accordingly, the slogans in the 1950s were: 'Small families have less problems' and 'Children of choice, and not by chance'.³⁵

Despite the generally perceived need, in January 1953 (just before the inauguration of the FPA), the president of the ACWC, Ezlynn Deraniyagala, refused to include family planning in the ACWC agenda. She expressed this in *The Ceylon Observer*:

The General committee is aware that our membership represents every type of opinion, has always felt that there was more than sufficient work to be done on non-controversial issues, and that subjects like family planning could best be pursued by those interested in them, either individually or through some other appropriate organisation.³⁶

Mrs Deraniyagala attended the inaugural meeting of the FPA (held in the form of a tea party at Mrs Fernando's residence), but expressed her reluctance to take up family planning since it was a controversial issue. She also felt that there were other areas that ACWC should concentrate on to improve the health sector of the country. The Sri Lankan government spent much on eradicating tuberculosis in the early 1950s and Mrs Deraniyagala saw 'sterilisation and termination of pregnancy' as the need of the hour rather than family planning. She explained that spending on infected, diseased and weak infants who will face an early death was a waste of money. She suggested the sterilisation of 'diseased ignorant women'. Clearly, Deraniyagala's view on family planning had strong undertones of eugenics, more than any argument supporting birth control and family planning.

In reply to an article written by Mrs Deraniyagala in *The Ceylon Observer*, a professor of paediatrics at the University of Ceylon captured the political connotation of the term family planning. In the same column in the following week's paper, he defined family planning as 'a less offensive but more comprehensive name for contraception or birth control'.³⁷ He went on to explain that family planning did not raise any moral objections as it did not carry any coercive connotation. As I have pointed out earlier, policymakers and practitioners have not paid enough attention to the fine line dividing the terms family planning, contraception and birth control because they were keen to settle on a politically correct term. These newspaper articles and the FPA annual reports show that there was an attempt to define what family planning meant and the purpose it served in Sri Lanka at the inception of the Association.

From the time it was founded in 1953, the FPA discouraged abortion. In the Silver Jubilee Anniversary Souvenir of the FPA, Leila Basnayake, president of the FPA in 1977, shared her reminiscences of how Dr Siva Chinnatamby (the medical director of the FPA of Ceylon from 1959 to 1979) ‘gently but firmly’ refused a woman who wanted to undergo an abortion at the De Soysa maternity hospital.³⁸ One of the unique characteristics of the FPA is that its clinics provided and continue to provide fertility advice to women who have problems in conceiving. When Chinnatamby joined the FPA in 1959, she requested Mrs Fernando, secretary of the FPA, to let her practice her specialisation in fertility. Thereafter, the FPA made fertility clinics part of its programme.³⁹ This was indeed a very unusual characteristic, which was never spoken about or dealt with by the Sinhala Buddhist extremists who attacked the work of the FPA and Chinnatamby’s efforts. Family planning was criticised by extremists, especially in the 1960s, as being morally degrading and as a malicious scheme of the minority ethnic race, the Tamils—Chinnatamby was also a Tamil—to disturb the ethnic proportion of the country, disregarding the other useful services offered by the FPA.⁴⁰ Studying how rumours, paranoia and conspiracy theories serve local political rhetoric, D. Bass reminds us that sterilisation programmes in Up-country were framed around the same fear of changing the ethnic balance of the country even in 2007.⁴¹ These rumours reflected the anxieties that minority communities held vis-à-vis the government. Similarly, after the *vanda pethi* episode in 2018 in relation to violence in Ampara following claims that a particular Muslim restaurant was spiking its food with ‘sterilisation pills’, the Muslim community was severely criticised by the Sinhalese.⁴² Changing the ethnic balance is a common allegation directed at population and family planning programmes all over the world; thus, these charges are not specific to Sri Lanka.

In the 1960s, the services of the FPA were described by Abhayaratne and Jayawardena as ‘some children where there were none, fewer children where there were too many.’⁴³ Whether it is a development issue or a women’s health issue, family planning had gained momentum in Sri Lanka by the mid-1950s. And, as I mentioned earlier, the concepts of eugenics, birth control and family planning were all intertwined in the programme throughout the history of family planning in Sri Lanka. Government

policies and attitudes of the policymakers also played a role in blurring the boundaries between these concepts.

Family planning did not mean the same to everyone; as shown earlier, even the few upper-class people who attended the inaugural meeting of the FPA had no consensus on what family planning was for Sri Lanka. Some perceived family planning as synonymous with population control, while others saw it as an altruistic attempt to improve the lives of the destitute mothers. For some it was an effort at eugenics, aimed at the development of the state, while for others it was a personal intervention to achieve a greater good. Although both Dr Rutnam and Mrs Fernando were members of the ACWC, the topic of family planning was not welcome in the same. Family planning meant diverse things to different people, according to their personal and organisational objectives.

THE RELATIONSHIP BETWEEN THE STATE AND THE FPA

Although the FPA remained a non-governmental organisation (NGO), it sought the approval of the government for its activities. But FPA annual reports, contemporary newspaper articles and my interviews with past presidents show that the Government of Sri Lanka was not consistent in its support. The relationship remained cordial and supportive but, especially during general elections, the government took an indifferent stand. The opposition periodically criticised the party in power for supporting the 'immoral' cause of family planning, and the party in power regularly refrained from taking a stand on issues of family planning and population. However, the government supported the FPA in a number of ways, enabling it to carry out its work, but 'persistently refused to make any statement of policy, positive or negative, on the subject'.⁴⁴ When the FPA was granted funds by the government for the first time in 1954, it was on the condition that the FPA 'had to promise to keep it secret, for they feared the political fall-out if it were made known', said Phyllis Dissanayake, one of the founding members.⁴⁵

The initial grant given by the government to the FPA in 1954 was LKR 2,500.⁴⁶ The grant was first increased to LKR 10,000 per annum in 1956 and then to LKR 75,000 in 1957.⁴⁷ Even though the government grant

increased meteorically, the government did not take any policy decision on family planning. Interaction happened in other ways. The politicians in the 1950s had strong personal connections with the pioneers of the FPA, because they all belonged to the same social strata. Politicians and family planners did cooperate in their activities, but were careful not to make this cordial relationship visible to the public eye.

Despite its reluctance to take up the cause of family planning in the early 1950s, the Sri Lankan government signed an agreement with the Swedish government to conduct a pilot study-cum-action Family Planning Programme in 1958.⁴⁸ This was the first agreement of its kind between two governments on conducting a family planning project.⁴⁹ According to this agreement, the Swedish government offered LKR 3,000,000 to start a pilot project in two or more rural areas.⁵⁰ Hyrenius and Ahs believe that the main purpose of this project was to

investigate attitudes towards family planning, the prospects for family planning activities, to give the population instruction in the methods of family planning and to assist in training Ceylonese public health staff in work of this kind.⁵¹

The project was implemented in Bandaragama (a village 25 miles south of Colombo, predominantly a Sinhalese Buddhist agricultural community) and Diyagama (a tea estate in the hill country, predominantly a Tamil Hindu plantation community).⁵² A Swedish physician and a nurse were sent by the Swedish International Development Cooperation Agency (SIDA) to 'conduct the Pilot Trial using chemical and mechanical methods to see if Ceylonese were "planning minded" and to ascertain the best method to be advocated for fertility regulation'.⁵³ Why was Sweden interested in funding a family planning programme on a small island in the Indian Ocean when they had no colonial interest in Sri Lanka? Or, to put it differently, what was so attractive about Sri Lanka for the Swedes to fund a family planning project in the 1950s? Given the global context, population control in Asia became the responsibility of the West for its own economic and security reasons. Against such a historical background, why was Sri Lanka chosen over other countries by the Swedish government for funding the first ever government-assisted family planning programme in the world?⁵⁴

FUNDING POPULATION CONTROL PROGRAMMES

The US and Sweden were the first countries to fund population and family planning programmes in the late 1950s.⁵⁵ ‘Total funding for population and family planning by donor governments increased from \$13.6 million in 1965 (Donaldson, 1990) to \$980 million in 1994 (United Nations Population Fund 1999).’⁵⁶ As Hartmann points out, the United States’ funding for population programmes (research and implementation strategies) in the Third World was more an economic and security measure than a charitable endeavour. Following a robust eugenics career, the Swedish government was one of the very first to support family planning programmes and movements in the early 1960s to train the first generation of family planning leaders in developing countries.⁵⁷ As mentioned earlier, the Swedish government assisted Sri Lanka in organising a population project in community family planning from 1958 to 1983.⁵⁸ ‘Swedish aid to Sri Lanka during this 25-year period was SEK 33m, of which, since 1972, 18 per cent was used “for building and construction, 41 per cent for supplies of contraceptives and 35 per cent for equipment.”’⁵⁹ These initiatives were the results of the writings of economic demographers Ansley Coale and Edgar Hoover, and economists Stephen Enke and Gunnar Myrdal.⁶⁰ However, according to the evaluation report of 1984, the experience gained from the first family planning programme conducted in Ceylon in 1958 became useful in the design of the national programmes of other countries in the future.⁶¹ In other words, Sri Lanka was used as a testing laboratory for family planning programmes by the developed countries. As I have mentioned before, Sri Lanka was chosen as a social laboratory to conduct research on health, social medicine, population growth, and cultural and economic change in the 1950s. As one social scientist wrote,

Ceylon’s unique importance as a social research locale rests in the manifestation of problems and processes which are not only Ceylonese but Southeast Asian. There is much to support the view that Ceylon approximates a microcosm of Southeast Asia which is both stable and of workable size.⁶²

With the signing of the agreement for the pilot project on family planning with Sweden, Sri Lanka officially became a laboratory in which to design family planning programmes for South Asia. Sri Lanka’s laboratory status

was strengthened in 1961 with the undertaking of clinical trials for the introduction of the birth control pill to South Asia, which I will address in Chapter 3.

FAMILY PLANNING AS PART OF PLANNING IDEOLOGY IN THE 1950s AND 1960s

In 1962, Prime Minister Sirima Bandaranaike proposed the incorporation of family planning into the maternal and child health programme of the Ministry of Health.⁶³ Prior to her entry into national politics (upon the death of her husband, the previous prime minister, in 1959), she had worked as a volunteer at the FPA with other elite women. This was the first time that the leader of the state acknowledged the efforts of the FPA. Nevertheless, the then Minister of Education vehemently disapproved of family planning. He wrote in a Sinhalese daily, 'I am fully against family planning, and I consider it murder.'⁶⁴ Being a great supporter of the nationalism propagated by Mr Bandaranaike in the late 1950s, he used the term 'murder' in two senses. First, he used it in the sense of disallowing children to be born. Second, he meant the murder of the nation (the Sinhala Buddhist nation) as a consequence of family planning. His nationalist ideas did not allow him to perceive family planning as a mechanism by which women could take charge of their bodies and reproductive processes, because women's bodies were bestowed with the responsibility of nation-building in independent Sri Lanka.

Despite the opposition of some government ministers, in October 1965, the government made family planning part of its programme and took over 150 family planning clinics previously run by the FPA. Moreover, the Family Planning Bureau was established under the direct administration of the assistant director of maternal and child health.⁶⁵

By placing family planning under the purview of maternal and child health, the government recast family planning as a preventive health service for mothers. This in turn helped to provide an ideological legitimacy and respectability to the taboo topic of family planning. I see this as a moment that aligned women's reproductive behaviour with the development priorities of the state. In Chapter 1, I discussed how the official rhetoric equated women's health with reproductive health. Thus,

women were positioned at the centre-stage of the state development discourse as primary sites of change. As mentioned in Chapter 1, the government's move to take on the question of family planning could be seen as an example of the zeitgeist of the national planning ideology.

On the very first page of the *Annual Report of 1963-64* of the FPA, family planning is defined as '*pavul sanvidanaya yanu sanvidanathmaka demavpiyabavayay*', which means 'planned parenthood is family planning'.⁶⁶ Even though Planned Parenthood is an international organisation with the motto 'every child is a wanted child', FPA used the concept of planned parenthood to emphasise the planning ideology of the 1960s. By the end of the decade, the aim of the FPA was 'to make family planning a way of life for all our people and not only for the more affluent'.⁶⁷

With family planning becoming a part of the state-building project, the FPA's role narrowed to 'helping to train doctors and paramedical staff, and to educating the public particularly in rural and estate areas about the meaning of Family Planning'.⁶⁸ Thus, the FPA became the educational and propaganda arm of the state family planning programme and acted as a catalyst to change the attitudes of the public. The role of the FPA changed from conceptualising family planning to creating a 'common sense' on family planning. On 5 May 1965, Minister of Finance U. B. Wanninayake declared the FPA an approved charity under Section 67 (1) of the Inland Revenue Act No. 4 of 1963.⁶⁹

The agreement with the Swedish government ended in 1963, and in 1965 a new agreement was signed. 'By 1969, 2000 midwives, 800 health inspectors, 300 nurses and 200 doctors had received education in family planning'.⁷⁰ Suggestions and training provided by the Swedish government for conducting a national family planning programme led to a discussion on incorporating sex education into the school curriculum. After much debate and contemplation, this proposal was rejected. However, population education was introduced in 1972 as part of the \$6 million multidisciplinary United Nations Fund for Population Activities (UNFPA) project by incorporating population education into five subject areas, namely 'science, social studies, mathematics, health education and the first languages'.⁷¹

IMPLEMENTING FAMILY PLANNING AS POPULATION CONTROL PROGRAMMES IN THE 1970s

As mentioned in Chapter 1, in 1972–73, the government declared a national policy on family planning in its Five-Year Plan (1972–76).⁷² This was also part of the UNFPA-funded multidisciplinary population programme. Since the government took direct responsibility for family planning services and expansion, it appeared necessary to rethink the role of the FPA in the early 1970s. The FPA was careful enough to refrain from duplicating the family planning activities and services offered by the government.

Even though the government undertook family planning on a major scale, it left important issues such as sterilisation outside its scope. In order to address this gap, the FPA shifted its emphasis from family spacing to family limitation, from condom, pill, IUD and injection to tubectomy and vasectomy by 1973.⁷³ Thus, population control measures were introduced through the FPA in the 1970s, while the government adhered to a family planning programme. This was quite different from the Indian approach to sterilisation. The Indian government introduced sterilisation in 1959 as part of its programme and conducted abusive sterilisation camps during 1975–77.⁷⁴ However, the Government of Sri Lanka carefully left this politically costly and conflicted area to the FPA, an NGO.

Why did the FPA change its focus from family planning to population control in the early 1970s? Hartmann noted that one of the four main areas of the United States Agency for International Development (USAID) was population control during this time.⁷⁵ According to Brian Atwood, administrator of the USAID, this was a period of waging war on population growth with multiple weapons such as the unmet need for contraceptives, maternal health, prenatal care, safe sex, social education and women's empowerment.⁷⁶ As one of the main funders, USAID enjoyed the privilege of pressuring the UNFPA to conduct all-encompassing population programmes.⁷⁷ Thus, as part of the UNFPA multidisciplinary population programme, the FPA became associated with the ministries of labour, information and broadcasting, health, education, local government and home affairs, and played a vital role in managing the 11 projects to control the population growth rate of the country.⁷⁸

By the early 1970s, the unmet need for contraceptives was addressed through the programme on social marketing of contraceptives. In 1974, the Pill became an over-the-counter drug in Sri Lanka. That same year, Ayurvedic physicians were trained in family planning methods in order to take the Pill to rural areas. A youth volunteer programme was set up in 1975 to educate rural populations on family planning.⁷⁹ The decade of the 1970s had a special significance in shaping the future of the young population of Sri Lanka due to two reasons. First, the youth uprising in 1971 drew attention to the high rates of unemployment. Second, the opening of the Sri Lankan economy to Western entrepreneurs in 1977 created job opportunities in factories of the free trade zone in Katunayake. The Sri Lankan youth at this time were largely unemployed. They were educated in village schools where they had imbibed strong Sinhalese Buddhist chauvinistic ideas. They were commonly known as *panas haye daruwo* (children of '56), the product of Prime Minister Bandaranaike's (1956–59) language policy generally known as the Sinhala Only Act of 1956.⁸⁰ Due to this policy, they failed to develop the necessary English-language skills to compete in the job market with their peers who had been educated in city schools. The frustration of unemployment and under-employment led to the first youth uprising of independent Sri Lanka in 1971.⁸¹

THE ROLE OF YOUTH IN POPULATION EDUCATION

Sri Lanka's UNFPA/UNDP-driven population programme was launched in 1972–73. Almost all ministries became involved in the programme and made sure that information on family planning and contraception, which until then had been strictly limited to married couples, spread to the youth of Sri Lanka. The FPA formed a Youth Committee in 1975 to take the message of family planning and planned parenthood to rural areas because of the high proportion of youth—by 1975, 73 per cent of the population was under 35 years—and to conform to the International Planned Parenthood Federation's (IPPF's) emphasis on involving the youth in population activities.⁸² Activities of the Youth Committee were further facilitated through the setting up of a volunteer system in 1976. When I inquired about youth involvement in family planning from the

first executive director of the FPA (1975–2005), he said that ‘the volunteer system paved the way to take sexual and reproductive knowledge to the grassroots.’⁸³ He was quite proud of this achievement since it had been set up during his tenure and is still running. He added triumphantly that the ‘volunteer system was the most successful programme ever introduced by the FPA’⁸⁴

It became evident through the discussions that I had with retired FPA officials that the youth volunteer programme was a pragmatic move to get the youth involved in discussions on family planning and population problems in rural areas after the first youth uprising (*Janatha Vimukthi Peramuna* [JVP]—People’s Liberation Movement) in 1971. The purpose was to give this group of educated people—with vernacular skills and an imbibed Sinhalese Buddhist ideology—the opportunity to perform to their abilities and contribute to development planning by addressing a ‘dire social problem’ faced by the country. Even though the youth volunteer programme appeared to be very successful and pragmatic at first glance, I found it difficult to comprehend how it was possible for young people to promote family planning among villagers in a society where sex was a topic discussed exclusively by the married. When I inquired after this from the former executive director of the FPA, he said

Since they were considered the ‘children of 56’, they were well-respected in the rural areas. So it wasn’t an issue in the mid-1970s for them to talk about family planning, and at the same time they made it very scientific, so people didn’t feel that they were discussing a taboo topic.⁸⁵

By ‘respect’ he meant a certain hegemonic status that the ‘children of 56’ enjoyed in rural areas. In fact, during a brainstorming session at a youth workshop conducted by the FPA in 1974, the young participants proposed to call the FPA of Sri Lanka an ‘Organisation for the Protection of Society’ and to work towards erasing the misconceptions about family planning at the village level.⁸⁶ The Youth Committee of the FPA organised seminars on population education in the project areas all over the country—Jaffna, Weligama, Harispattuwa and Badulla. Additionally, three seminars were held at university campuses and in three leading schools on request.⁸⁷ In retrospect, scholars see this youth involvement in the population problem

as an activity geared towards ‘preparing a generation of family planning leaders in developing countries’, which allowed the West to perpetuate the status quo, that is, to retain its superior position, through controlling the ‘problem populations’ of the East.⁸⁸ Getting the youth involved in family planning activities helped create a ‘cult of population control’ among policymakers and the implementers of family planning programmes in Sri Lanka by the late 1970s.⁸⁹ Apart from the youth, on the suggestion of the IPPF, the FPA trained another group in family planning activities to reach the villagers—the Ayurvedic physicians.

Ayurvedic physicians were one of the five forces that Mr Bandaranaike wanted to groom to be leaders in rural areas, as he stated in 1956 during his election campaign.⁹⁰ In 1974, they were approached by the IPPF through the FPA to take the family planning message and the Pill to the rural areas. I identify them as the most appropriate group that possesses the traditional and cultural hegemony necessary to address and influence rural communities to carry out the planning ideology of the state.

Seeking the Support of Ayurvedic Physicians

Hartmann scorned the alienation of traditional local healers and midwives instead of winning them over and involving them in the modern family planning programmes in Egypt, but the situation in Sri Lanka was quite the contrary.⁹¹

At the first International Scientific Congress of the FPA of Sri Lanka in 1974, Dr Malcom Potts, Director-General of the IPPF, stressed the importance of winning the support of the traditional Ayurvedic physicians for the modern family planning programme in order to convey the knowledge and message to the rural areas. Addressing Ayurvedic physicians, he said,

You have a skill with people that the Western doctor often lacks. The Prime Minister, the IPPF Secretary General, and many of us have welcomed the participation of ayurvedic doctors. We at this conference say ‘Please help us. Please take the Pill we have invented and tell us how to distribute it.’ In other words we have done the easy part, now please help us with the difficult bit. Perhaps we should say that we are very sorry we have been so taken up with our microscopes and statistics that we failed to consult you earlier.⁹²

According to the 1901 census, there were 3,424 *vedaralas* (traditional medical practitioners, later called Ayurvedic physicians) in the country. Ayurveda, Siddha and Yunani were the traditional medical practices in Sri Lanka prior to the introduction of Western medicine during the colonial period. In the 1970s, there were 10,163 registered traditional medical practitioners in Sri Lanka.⁹³ According to Potts' suggestion, a three-day training programme on family planning for Ayurvedic physicians was carried out by the Family Health Bureau (FHB) and the department of Ayurveda in November 1975. At this workshop, 165 Ayurvedic physicians from all over the country were trained. The FHB received funds from the IPPF through the FPA to conduct this training programme, and by 1977, over 800 traditional Ayurvedic physicians had been trained.⁹⁴ These programmes were carried out in 'Colombo, Kurunegala, Galle, Kandy, Jaffna and Ratnapura'.⁹⁵ By the 1980s, the Ayurvedic physicians were advocating family planning methods to the rural peasants in order to service the development project of post-independence Sri Lanka.

The involvement and commitment of both these groups—youth and Ayurvedic physicians—were significant to the cause of family planning, both locally and internationally. Borrowing an anthropological term, Sarath Amunugama termed Ayurvedic physicians as 'cultural brokers' for the various services they provided as ideological and cultural leaders of the community.⁹⁶ Strategies put forward by the global population programme (getting the support of the traditional leaders of society, for instance) blended very well with the contemporary local scenario. Thus, controlling the population growth rate became the top priority in the family planning programme, and at the same time the 'cult of population control' got deeply and soundly rooted in Sri Lanka. With these initiatives, the idea of family planning reached the masses by the end of the 1970s.

Ayurvedic medicine and Western-style biomedicine are practised 'side-by-side' in Sri Lanka. Patients decide which physician to consult according to the ailment, and sometimes both an Ayurvedic physician and a Western medical doctor are consulted together with a ritual practitioner and an astrologer.⁹⁷ Quoting Indrani Pieris on the health behaviour of Sri Lankans, Jones says that 'Sri Lankans use all systems, both official and non-official, interchangeably and also in tandem'.⁹⁸ Scholars studying traditional medical systems in the world have shown how plural medical

systems co-exist, especially in countries with colonial pasts.⁹⁹ Even though Ayurvedic physicians were trained to deliver family planning services to the rural masses from 1975 to 1980, family planning is not in their purview anymore. In retrospect, it is evident that Ayurvedic physicians were deployed by the IPPF to publicise the Pill among the rural masses. However, as mentioned earlier, patients decide whom to consult about their health issues. Today there is a thriving market for Ayurvedic physicians for issues concerning infertility, but women seek family planning advice from midwives in the public health sector.

The FPA *Annual Report of 1969–70* reported a problem with the way in which the meaning of family planning was perceived by the people. It states that family planning has become synonymous with contraception for village folk, which made them suspicious of the Association.¹⁰⁰ According to my reading, the absence of a Sinhalese term for contraception is the subtext of this statement. Contraception is either translated as *upath palana krama* (birth control methods) or as *pilisindagæneema walakvana vidyanukoola krama* (ways of scientifically regulated methods to stop conception). The terms ‘control’ (*palanaya*) and ‘stop’ (*walakvana*) used in Sinhalese do not articulate the liberating, empowering aspect of contraception, but instead emphasises an authority over women’s bodies. In other words, the shift from (*palanaya*) control to (*saelasum kireema*) planning, which was clearly articulated within the global population discourse, was not captured through the Sinhalese translation. So it was inevitable that family planning became equivalent to contraception in Sri Lanka. My oral history interviews also supported this archival evidence.

During my interviews with retired school teachers, I had noticed that they used both terms—birth control (*upath palanaya*) and family planning (*pavul saelasum kireema*)—in Sinhalese interchangeably. I asked them whether they see or feel any difference between these terms. For some, the implications of both terms were the same. A Sinhalese language teacher explained to me in detail that though birth control and family planning do mean different things, this difference is not marked within day-to-day usage. Ultimately, the meanings of both these terms converge to control population growth.¹⁰¹ As a consequence of these initiatives and the energetic promotional campaign carried out by the Ministry of Plan Implementation, the planning ideology was firmly established by the late 1970s.

THE FAMILY PLANNING PROGRAMME DURING THE DYNAMIC IMPLEMENTATION MODE OF THE LATE 1970s

As mentioned in Chapter 1, although there was a change in government in 1977 with the election of President J. R. Jayawardena of the United National Party (UNP), the UN-funded population programme was continued with much vigour. In 1977, a population division was set up in the Ministry of Plan Implementation. The election manifesto of the UNP clearly emphasised the commitment to a vigorous population policy and family planning programme.

Enhanced family planning services will be provided by the State and financial incentives with a view to controlling the population explosion will be given to individuals who practice them.... In the field of FP, emphasis of the Government will be in the field of service oriented programmes to enable motivated couples and individuals to receive family planning services and to undergo vasectomy or sterilization voluntarily.¹⁰²

Government tax policies were also reoriented in favour of small families. This was illustrated in the budget speech of the Minister of Finance in 1978:

The allowance of Rs. 12,000 will be a fixed amount and will not vary with the number of children. I trust this will be an appropriate disincentive to large families. It is my intention to introduce further tax disincentives to large families in due course. Population growth must be curbed if we are to achieve our objectives of eliminating unemployment, shortage of food and housing, and the depletion of our natural resources. Tax policy will be geared to this end.¹⁰³

Under the 1977 government, the family planning programme was revamped in line with the development plans of the state, emphasising the Mahaweli Development Programme, the free trade zone and labour migration of semi-skilled workers to the Middle East.¹⁰⁴ Monetary incentives were introduced for voluntary sterilisation in the mid-1970s.¹⁰⁵ It was India that took the initiative of introducing the first large-scale incentive scheme of cash payments on a vasectomy programme in the late 1960s.¹⁰⁶ Following the Indian example, by 1979 Sri Lanka extended its incentive scheme to the motivator and the provider, which meant cash

payments to the surgical team as well.¹⁰⁷ Under this scheme LKR 65 is paid for a female sterilisation and LKR 35 for a male sterilization.¹⁰⁸ Further, the incentive scheme was augmented by providing leave to all those who accepted voluntary sterilisation. Men were given three and women were given seven full days of paid leave. Initially, the cash incentive was LKR 100 for acceptors of voluntary sterilisation; from October 1980, this payment increased to LKR 500 and then reduced to LKR 200 in February 1981. By the end of 1981, it again increased to LKR 300 and finally in June 1983, this was settled at LKR 500 per head.¹⁰⁹

Even though the former medical director of the FPA claimed that Sri Lanka was not considered to have been conducting an abusive sterilisation programme in the 1980s, my interview with the retired secretary of the Ministry of Plan Implementation painted a different picture. When he was explaining the energetic population control programme that he had led in the 1980s, he said

Even though abortion is still illegal in Sri Lanka, I supported the abortion clinics and in fact, I used to provide those doctors with menstrual regulatory kits, because my population policy was to somehow stop children being born for the sake of developing the country.¹¹⁰

That is to say, to do everything in his power to meet the target of stopping children from being born, he amended the incentive scheme accordingly by monitoring the sterilisation programme very closely. He also told me about instances wherein he helped the staff of abortion clinics that were raided by the police to be released from custody.

According to a circular issued by the Ministry of Health on 10 October 2013, sterilisation incentives were stopped with effect from 17 November 2013.¹¹¹ Even though Sri Lanka made a conceptual shift from family planning to reproductive health and rights in 1996 as advocated by the ICPD in 1994, remnants of old notions still remain part of the women's health programme.¹¹² These remnants prove the point made by the professor of demography, mentioned at the beginning of this chapter, about the Sri Lankan policymakers' lack of understanding of global conceptual shifts.

In the global women's health literature, the family planning programme of Sri Lanka is considered a fair and just programme when compared to the

Indian situation.¹¹³ However, an attentive researcher cannot miss the hints of an implicit population control in measures such as slogans, logos and maternity leave provision in the era of development plan implementation. *Punchi pavula raththaran* ('a small family is golden') was one of the slogans that all my interviewees remembered, but surprisingly, nobody knew who came up with it originally.¹¹⁴ Even though it was impossible to find the original author of the slogan, the retired secretary of the Ministry of Plan Implementation showed me the picture he designed to accompany this slogan during his tenure. In his contribution to the book *ICPD—15 Years On*, he mentioned that he got the painting (see Image 2.1) from a 'famous image of our ancient temples'.¹¹⁵ However, in the interview, he explained to me that the painting was created imitating the style of old temple drawings. Thus, he used this style to spread the idea that a family with two children has been the norm since ancient times.

When I expressed my surprise, he said quite defiantly,

Who is going to question me on this now? Even if I'm questioned, I will say that the painting is found in a temple in Dambulla, and who is going to cross check that? I used to do these type[s] of *gimmicks* in order to get things moving, you know?¹¹⁶

Image 2.1. Temple painting used for family planning motivation



Source: Weerasooria, W., 'Pre ICPD Activities on Population and Development in Sri Lanka (1977-1987)', in Bradman Weerakoon (ed.), *ICPD - '15 Years on' Sri Lanka*, Colombo, FPA, 2009, p. 4.

Taking such ‘gimmicks’ into consideration, I wonder whether we could still call these implementation methods fair, democratic and just. Was there not a hint of an implicit forcefulness in these programmes? As Hartmann suggests (in a very sympathetic note), family planning programmes in the Third World became forceful and undemocratic not through the ‘fault of individual health and family planning workers—they are themselves caught in a system where sensitivity in meeting women’s needs goes unrecorded, and merit is judged by how well they achieve population control targets.’¹¹⁷

This is indeed very true about the way in which the Sri Lankan family planning programme was implemented, especially in the 1980s. The main reason for this existing tension between terms, concepts and the policymaking process is that the policymakers of Sri Lanka are still neo-Malthusian in their thinking. They still ardently believe in a connection between population growth, food production and labour force that Malthus advocated in the eighteenth century. Thus, the family planning programme of Sri Lanka soon embraced the powerful ‘cult of population control’ by making the Pill an over-the-counter drug, introducing sterilisation incentives, training Ayurvedic physicians in family planning methods, establishing youth volunteer groups to educate villagers and introducing population studies in the school curriculum.

The ‘laboratory’ status of Sri Lanka was further entertained by local medical professionals who voluntarily undertook clinical trials of the Pill in 1961, which led to a further silencing of women’s bodies. Chapter 3 deals with the trajectory of the Pill in Sri Lanka, its rebranding as *Mithuri* (female friend) and its availability as an over-the-counter drug from 1974 to service the modern development project of independent Sri Lanka by subjugating women’s bodies to the dominant development ideology.

NOTES

1. Agreeing with Irene Taeuber’s (member of the Office of Population Research at Princeton, USA) ideas about Sri Lanka, Professor Bryce Ryan wrote to Dr M. C. Balfour, officer of the Rockefeller Foundation, that ‘Ceylon is ideal for a population analysis laboratory.’ In the mid-1940s, the Rockefeller Foundation began a period of assessment into its future role in health, which culminated

in the formation of the Division of Medicine and Public Health in 1951. Rockefeller Collection, Record Group 1.1/462, Box 1, Folder 2, Letter from Professor Bryce Ryan to Dr M. C. Balfour of the Rockefeller Foundation, 18 January 1950.

2. For the history and politics of global population control, see Gordon, *Woman's Body, Woman's Right*; B. Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice*, New York, Harper and Row, 1987; M. Connelly, 'Population Control is History: New Perspectives on the International Campaign to Limit Population Growth', *Comparative Studies in Society and History* 45 (Winter 2003), pp. 122–47; A. Bashford, 'Nation, Empire, Globe: The Spaces of Population Debate in the Interwar Years', *Comparative Studies in Society and History* 49 (1), pp. 1–32, and 'Internationalism, Cosmopolitanism and Eugenics', in *The Oxford Handbook of the History of Eugenics*, eds Alison Bashford and Philippa Levine, Oxford, Oxford University Press, 2010, pp. 154–72; and S. Hodges, 'Review Article: Malthus is Forever: The Global Market for Population Control', *Global Social Policy* 10 (1), 2010, pp. 120–26.
3. When I presented a paper titled 'Well-Woman Clinics: Shift in Women's Health in Sri Lanka' at the Population Association of Sri Lanka on 17 August 2011, a renowned professor of demography at the University of Colombo agreed that such a terminology shift would be the last thing to come to the minds of policymakers and demographers since population control is taken as the ultimate goal in women's health.
4. V. Shiva, 'After Fifty Years, is the World Bank Socially and Environmentally Responsible?' *Bulletin of Concerned Asian Scholars* 26 (4), 1994, 78–80.
5. A. Bashford, 'Internationalism, Cosmopolitanism and Eugenics', p. 164. Betsy Hartmann, Mohan Rao, Matthew Connelly and Ines Smyth, to name a few.
6. D. B. Paul and J. Moore, 'The Darwinian Context: Evolution and Inheritance', in *The Oxford Handbook of the History of Eugenics*, eds Bashford and Levine, p. 31.
7. S. Klausen and A. Bashford, 'Fertility Control: Eugenics, Neo-Malthusianism and Feminism', in *The Oxford Handbook of the History of Eugenics*, eds Bashford and Levine, p. 98.
8. Stoler, 'Making Empire Respectable', p. 644.
9. Wellcome Library, London, Reference to the pamphlets/programmes on the Birth Control in Asia Conference PP/EPR/F. 1/ 2. One Dr de Silva from Sri Lanka (then Ceylon) had attended this conference.
10. Hartmann, *Reproductive Rights and Wrongs*, p. 3.
11. *Ibid.*, p. 34.

12. S. M. Klausen, *Race, Maternity, and the Politics of Birth Control in South Africa, 1910–1939*, Palgrave Macmillan, 2004, p. 9.
13. Abhayaratne and Jayewardene, *Family Planning*, p. 2.
14. Jayawardena, *Dr. Mary Rutnam*, p. 16.
15. According to the *Ferguson's Ceylon Directory* (Colombo, Associated Newspapers of Ceylon Ltd., 1921), by 1921, 1,093,000 acres were under plantation while 798,000 acres were used to grow rice.
16. For the social and economic transformations of the colonial and post-colonial era, see Jayawardena, *Nobodies to Somebodies*; M. Roberts (ed.), *Collective Identities, Nationalisms and Protest in Modern Sri Lanka*, Colombo, Marga Institute, 1979; and A. Wright, *20th Century Impressions of Ceylon*, Lloyd's Greater Britain Publishing Co., 1999.
17. Jayawardena, *Dr. Mary Rutnam*, p. 14.
18. Jayawardena, *Feminism and Nationalism*, p. 128.
19. The Lady Havelock Hospital for Women and Children was established in 1895 in Borella (Colombo 8) and changed its name to Lady Ridgeway Hospital for Women and Children in 1910.
20. Jayawardena, *Feminism and Nationalism*, p. 121.
21. *Ibid.*, p. 21.
22. *Ibid.*
23. Abhayaratne and Jayewardene, *Family Planning*, p. 2.
24. *Ibid.*, p. 22.
25. *Annual Report of the Family Planning Association of Ceylon 1969–70*, Colombo, FPA, 1971, p. 3. See http://en.wikipedia.org/wiki/International_Planned_Parenthood_Federation (accessed on 29 July 2024).
26. The inaugural meeting was attended by Dr (Mrs) L. O. Abeyaratne (second president of the FPA), Professor O. E. R. Abhayaratne (professor of public health, University of Colombo), Dr (Mrs) F. R. Ram Aluwihare, Dr V Amirthalingam and Mrs Amirthalingam, Mrs Ezlynn Deraniyagala (president of the All Ceylon Women's Conference), Professor C. C. de Silva, Dr A. F. Outschoorn (took up a WHO position soon after), Dr Mary Rutnam, Dr P. R. Thiagarajah (senior obstetrician at the De Soysa Maternity Hospital) and Mrs E. C. Fernando (founding-secretary of the FPA until she retired in 1970). Colombo was the country's capital till 1977; today it remains the commercial capital of Sri Lanka.
27. C. C. de Silva (ed.), *A History of Family Planning in Sri Lanka 1953–1978*, Colombo, Silver Jubilee Souvenir of The Family Planning Association of Sri Lanka, 1979, p. 7.
28. P. Huston, *The Right to Choose: Pioneers in Women's Health and Family Planning*, London, Earthscan Publications Ltd., 1992, p. 41.

29. Advertisement, 'Daruduka' ('Feeling sad about infertility'), *Dinamina*, 25 May (Tuesday), 1948, p. 8.
30. 'Reminiscences of Dr Florence Ram Aluvihare, One of the Pioneers of the FPA of SL', in de Silva (ed.), *A History of Family Planning*, p. 21.
31. Ibid. See also S. Chinnatamby, 'Perspective in Safe Motherhood Over the Past Four Decades', Paper presented at the inter-regional meeting on safe motherhood, UNICEF, Colombo, 1992, p. 5.
32. The name of this hospital has changed over the years. It was established as the De Soysa Lying-in-Home in 1879, and in 1940 it was renamed as De Soysa Maternity Home. Again, in 1950, it became the De Soysa Hospital for Women. See <https://www.dmh.health.gov.lk/about-us/overview-history> (accessed on 29 July 2024)..
33. 'Family Planning The Only Way', *The Ceylon Observer* (Sunday Morning edition), 7 February 1954, p. 7; and Huston, *The Right to Choose*, p. 43.
34. de Silva (ed.), *A History of Family Planning*, p. 7.
35. Ibid., p. 13.
36. E. Deraniyagala, 'The Debate Goes On ... From the Casebook of a Social Worker...', *The Ceylon Observer*, 11 January 1953, p. 8.
37. Professor of Paediatrics of the University of Ceylon, 'The Debate Goes On ... A Doctor Replies to The Catholic Point of View ...', *The Ceylon Observer*, 18 January 1953, pp. 8, 9.
38. de Silva (ed.), *A History of Family Planning*, p. 13.
39. Huston, *The Right to Choose*, p. 52.
40. I discuss these ethnic connotations in Chapter 3 with regard to the Pill trials in Sri Lanka.
41. D. Bass, 'Paper Tigers on the Prowl: Rumors, Violence and Agency in the Up-Country of Sri Lanka', *Anthropological Quarterly* 81 (1), 2008, p. 280.
42. 'Women's Bodies, Masculinities and Economic Insecurities', Cat's Eye Column, *Financial Times*, online edition, 22 March (Thursday), 2018.
43. 'Training Activities by Ben Jayasinghe', in de Silva (ed.), *A History of Family Planning*, p. 109.
44. Abhayaratne and Jayewardene, *Family Planning*, p. 15.
45. Huston, *The Right to Choose*, p. 41.
46. *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, 1968, p. 40.
47. *Golden Jubilee Souvenir 1953–2003*, Colombo, FPA, 2003, p. 259.
48. *Annual Report of the Family Planning Association of Ceylon 1969–70*, p. 3.
49. Report on *Evaluation of Swedish Assistance for Family Planning in Sri Lanka*, May 1984, SRI DCO Archive, Report No. 27, Box No. 2.1/4, p. 2.

50. de Silva (ed.), *A History of Family Planning*, pp. 112–13.
51. H. Hyrenius and U. Ahs, *The Sweden-Ceylon Family Planning Pilot Project; Analysis and Evaluation*, undertaken on behalf of the Swedish International Development Authority (SIDA), Goteborg, 1968, p. 6.
52. *Ibid.*, p. 19.
53. Chinnatamby, 'Perspective in Safe Motherhood', p. 9.
54. For an insightful analysis of how funding for family planning programmes played a part in post-World War II global politics, see D. Thoradeniya, 'Altruism, Welfare or Development Aid? Swedish Aid for Family Planning in Ceylon (1958 to 1983)', *East Asian Science, Technology and Society: An International Journal* 10 (4), 2016, pp. 423–44.
55. J. R. Seltzer, *The Origins and Evolution of Family Planning Programs in Developing Countries*, New York, Rockefeller Foundation, 2002, p. 11.
56. *Ibid.*, p. 37.
57. W. C. Robinson and J. A. Ross (eds), *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*, Washington, DC, The World Bank, 2007, p. 3.
58. Report on *Evaluation of Swedish Assistance for Family Planning*, p. 1. See also Ministry of Plan Implementation, *Population and Family Planning Activities in Sri Lanka*, p. 11.
59. Report on *Evaluation of Swedish Assistance*, p. 1.
60. Robinson and Ross (eds), *The Global Family Planning Revolution*, p. 3. Gunnar Myrdal headed the group of experts who advised the National Planning Council of Ceylon in 1959.
61. Report on *Evaluation of Swedish Assistance*, p. 2.
62. Rockefeller Collection, Record Group 1.1/462, Box 1, Folder 2, letter from Ryan to Watson on 16 April 1950. Dr Robert B. Watson was the Director, Far Eastern Region, International Health Division of the Rockefeller Foundation, and Professor Bryce Ryan was the chairman of the sociology department at University of Ceylon (now University of Peradeniya) from 1948 to 1952, and consultant to the Rockefeller Foundation from 1950 to 1952.
63. *Annual Report of the Family Planning Association of Ceylon 1969–70*, 1970, pp. 4, 19.
64. Quoted in Wright, 'Recent Fertility Change', p. 755.
65. *Annual Report of the Family Planning Association of Ceylon 1969–70*, p. 4. See also de Silva (ed.), *A History of Family Planning*, p. 44.
66. *Annual Report of the Family Planning Association of Ceylon 1963–64*, Colombo, FPA, 1965, p. 1.

67. *Annual Report of the Family Planning Association of Ceylon 1969–70*, p. 15.
68. *Ibid.*, p. 19.
69. de Silva (ed.), *A History of Family Planning*, p. 121.
70. *Evaluation of Swedish Assistance for Family Planning in Sri Lanka*, SIDA/ISO, Stockholm, May 1984, p. 7.
71. *New Dimensions in Population Planning and Development: International Congress, Silver Jubilee Celebrations*, Colombo, FPA, 1978, pp. 103–04.
72. Ministry of Plan Implementation, *Population and Family Planning Activities in Sri Lanka*, p. 26.
73. de Silva (ed.), *A History of Family Planning*, p. 155.
74. R. Simon-Kumar, 'Marketing' *Reproduction? Ideology and Population Policy in India*, New Delhi, Zubaan, 2006, p. 102.
75. Hartmann, *Reproductive Rights and Wrongs*, p. 114.
76. *Ibid.*, p. 115.
77. *Ibid.*, p. 116.
78. *Annual Report of the Family Planning Association of Sri Lanka 1975*, Colombo, FPA, 1976, p. 5.
79. The Pill became freely available and adapted to local conditions as *Mithuri* through the programme of social marketing of contraceptives launched in 1974. I have discussed this programme in greater detail in Chapter 3.
80. In 1956, keeping to his election promise, Bandaranaike replaced English with Sinhala as the official language of Sri Lanka. This is commonly known as the Sinhala Only Act of 1956. Scholars identify this as the beginning of the discriminatory treatment meted out to minority Tamils in Sri Lanka, which paved the way for a 26-year ethnic war.
81. For an insightful analysis of the 1971 JVP uprising, see V. Ivan, *71 Kerella; Janatha Vimukthi Peramune Arambaya ha Vikashanaya (1964–1971)*, Borelesgamuwa, Ravaya Publications, 2010, 4th edn; R. Gunaratne, *Sri Lanka, a Lost Revolution? The Inside Story of the JVP*, Kandy, Institute of Fundamental Studies, 1990; G. Samaranayake, 'The Changing Attitude Toward the Tamil Problem within the Janatha Vimukthi Peramuna', in *Facets of Ethnicity in Sri Lanka*, eds C. Abeysekera and N. Gunasinghe, Colombo, Social Scientists' Association, 1987, pp. 272–97; Uyangoda, 'Social Conflict, Radical Resistance'; S. T. Hettige, *Wealth, Power and Prestige: Emerging Patterns of Social Inequality in a Peasant Context*, Colombo, Ministry of Higher Education, 1984; and A. C. Alles, *The JVP 1969–1989*, Colombo, Lake House Investments Ltd, 1990. The second JVP uprising took place in 1989, which I have discussed in detail in Chapter 4.
82. *Annual Report of the Family Planning Association of Sri Lanka 1975*, p. 6.

88. Interview with the first executive director of the FPA (1975–2005) on 21 December 2009 at his residence in Rajagiriya.
84. Ibid.
85. Ibid.
86. *Annual Report of the Family Planning Association of Sri Lanka 1975*, p. 35.
87. Ibid., p. 36.
88. Robinson and Ross (eds), *The Global Family Planning Revolution*, p. 3.
89. Hartmann, *Reproductive Rights and Wrongs*, p. 104.
90. The five forces, as he called them, were *sangha* (Buddhist priests), *veda* (Ayurvedic physicians), *guru* (school teachers), *govi* (farmers) and *kamkaru* (labourers). His election promise to make Sinhala the official language of the state attracted these five forces by offering them the prospect of a privileged position in the villages.
91. Hartmann, *Reproductive Rights and Wrongs*, p. 64.
92. de Silva (ed.), *A History of Family Planning*, p. 33.
93. K. Pieris, *The Medical Profession in Sri Lanka 1843–1980*, Borelesgamuwa, Visidunu Publications, 2001, p. 78.
94. de Silva (ed.), *A History of Family Planning*, p. 154.
95. *Annual Report of the Family Planning Association of Ceylon 1976*, Colombo, FPA, 1977, p. 18.
96. S. Amunugama, 'Sociological Factors in Family Planning Publicity Programmes', in *Report of a Seminar on Population Problems, Held for Representatives of the Mass Media*, Bangkok, UNESCO Regional Office for Education in Asia, 1974, p. 23.
97. For an insightful analysis of Sri Lankans' health behaviour and the way indigenous medical systems and bio-medical systems are practised in Sri Lanka, see G. Obeyesekere, 'The Impact of Ayurvedic Ideas on the Culture and the Individual in Sri Lanka', in *Asian Medical Systems*, ed. Charles Leslie, Berkeley, University of California Press, 1976, pp. 201–26; I. Wolffers, 'Traditional practitioners' behavioural adaptations to changing patients' demands in Sri Lanka', *Social Science & Medicine* 29 (9), 1989, pp. 1111–19; I. Pieris, *Disease, Treatment and Health Behaviour in Sri Lanka*, New Delhi, Oxford University Press, 1999; M. Jones, *The Hospital System and Health Care Sri Lanka, 1815–1960*, New Perspectives in South Asian History, New Delhi, Orient BlackSwan, 2009; M. Jones and C. Liyanage, 'Traditional Medicine and Primary Health Care in Sri Lanka: Policy, Perceptions, and Practice', *Asian Review of World Histories* 6, 2018, pp. 157–84.
98. M. Jones, 'A Bounded Medical Pluralism: Ayurveda and Western Medicine in Colonial and Independent Sri Lanka', in *The Development of Modern Medicine*

- in *Non-Western Countries: Historical Perspective*, ed. Hormoz Ebrahimnejad, London & New York, Routledge, 2009, p. 121.
99. N. Waxler ('Behavioural Convergence and Institutional Separation: An Analysis of Plural Medicine in Sri Lanka', *Culture, Medicine and Psychiatry* 8, 1984, pp. 187–205) gives an overview of the scholarship of P. Brass, 'The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India', in *Education and Politics in India*, eds S. J. Rudolph and L. I. Rudolph, Cambridge, Massachusetts, Harvard University Press, 1972; A. C. Colson, 'The Differential Use of Medical Resources in Developing Countries', *Journal of Health and Social Behavior* 12, 1971, pp. 226–37; R. Elling, 'Relations between Traditional and Modern Medical Systems', *Social Science and Medicine* 15A, 1981, pp. 87–88; H. Gould, 'Modern Medicine and Folk Cognition in Rural India', *Human Organization* 24, 1965, pp. 201–08; N. S. Gonzalez, 'Health Behavior in Cross-Cultural Perspective: A Guatemalan Example', *Human Organization* 25, 1966, pp. 122–25; H. K. Heggenhougen, 'Bomohs, Doctors and Sinsehs: Medical Pluralism in Malaysia', *Social Science and Medicine* 14B, 1980, pp. 235–244; C. Leslie, 'The Professionalizing Ideology of Medical Revivalism', in M. Singer (ed.), *Entrepreneurship and Modernization of Occupational Culture of South Asia*, Durham, Duke University Press, 1973; M. Lock, *East Asian Medicine in Urban Japan*, Berkeley, University of California Press, 1980; A. Kroeger, 'Anthropological and Socio-Medical Health Care Research in Developing Countries', *Social Science and Medicine* 17, 1983, pp. 147–61; and L. Slikkiveer, 'Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers', *Social Science and Medicine* 16, 1982, pp. 1859–72, on traditional medical practices and practitioners in the world.
 100. *Annual Report of the Family Planning Association in Ceylon 1969–70*, p. 12.
 101. Interviews with Mrs Vida at an orphanage in Wellawatta where she volunteers, 14 June 2010; Mrs Jaya, at her residence in Kohuwala, 5 July 2010; Mrs Perera at her residence in Piliyandala, 14 July 2010; and Mrs Dhana at her residence in Maharagama, 24 July 2010.
 102. Ministry of Plan Implementation, *Population and Family Planning Activities in Sri Lanka*, p. 12.
 103. *Ibid.*
 104. For a detailed discussion on the economic changes of 1977 in relation to women's bodies, see Chapter 1.
 105. Symonds and Carder point out that there was a debate in the late 1960s within the UN on promoting effective family planning measures. Encouraging late marriages and incentives for smaller families were two such decisions that

- emerged from the debate. See R. Symonds and M. Carder (eds), *The United Nations and the Population Question 1945–1970*, London, Chatto & Windus for Sussex University Press, 1973.
106. V. de Silva, S. Thapa, L. R. Wilkens, M. G. Farr, K. Jayasinghe and J. E. McMahan, 'Compensatory Payments and Vasectomy Acceptance in Urban Sri Lanka', *Journal of Biosocial Science* 20 (2), 1988, p. 143.
 107. *Ibid.*, p. 144.
 108. *Voluntary Sterilization Programme in Sri Lanka*, Colombo, Population Division, Ministry of Plan Implementation, 1983, p. 13.
 109. *Ibid.*, pp. 13–14. See also de Silva et al., 'Compensatory Payments and Vasectomy Acceptance', pp. 144–45; and W. I. de Silva, 'Do Fertility Intentions and Behaviour Influence Sterilization in Sri Lanka?' *Asia Pacific Population Journal*, 7 (4), 1992, p. 57.
 110. Interview with the retired secretary to the Ministry of Plan Implementation on 7 August 2011 at his office in Colombo.
 111. General Circular FHB/FB/21/2013, Cancellation of the 'out of pocket allowance' paid to clients who voluntarily undergo sterilisation.
 112. I will discuss the 'controlled and planned' mindset of the policymakers of Sri Lanka in Chapter 5.
 113. Health professionals that I interviewed took the sterilisation camps in India as counter example to defend the Sri Lankan programme.
 114. All the retired teachers, members of the FPA, officials at the FHB and midwives remembered the slogan: 'small family is golden' (*Punchi Pavula Raththaran*), which was publicised with full force in the 1980s.
 115. Weerasooria, 'Pre-ICPD Activities on Population and Development', p. 4.
 116. Interview with the retired secretary of the Ministry of Plan Implementation on 7 August 2011 at his office in Colombo; emphasis his.
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3

Sri Lanka

Birth Control Pill Trial Site for South Asia
(1950–80)¹

INTRODUCTION

The journey of the Pill from the Worcester Foundation in Massachusetts to the De Soysa Maternity Hospital in Colombo was of historical significance in writing a critical history of women's health in modern Sri Lanka. To begin with, Sri Lanka became the first country in South Asia to voluntarily undertake clinical trials of the Pill in 1961, thus establishing its position as a social laboratory. Second, the clinical trials of the Pill established a link between the FPA and the government, paving the way for the government to officially adopt family planning in 1965. Medical practitioners in Sri Lanka saw the Pill trials as a great contribution towards global medical research, while family planners considered the Pill a panacea for development.² Sri Lanka was in 'planning mode' in the late 1950s and the birth control pill came into being at a crucial time, as it helped to plan the unplanned families of Sri Lanka.

The first part of this chapter examines the role played by Sri Lanka with regard to the international efforts employed in developing and delivering the Pill to South Asia. I will provide a brief history of the initiator, Dr Siva Chinnatambay, and the trial venue, the De Soysa Maternity Hospital for Women in Colombo, in order to understand the broader context of the Sri Lankan Pill trials. Within this historical account, I will highlight the strong planning ideology that prevailed in Sri Lanka in the late 1950s that created a link between the FPA and the government, culminating in the

clinical trials of the Pill in 1961. This in turn spurred the public health sector to take family planning on board in 1965.

The second part of this chapter focuses on how Sinhalese Buddhist nationalists described the Pill as *vanda pethi* (sterility pills) in the 1960s and saw it as an attempt to disturb the ethnic balance of the country. It also discusses the working of market forces in the Pill's rebranding in the 1970s. A decade-and-a-half later, when the Sri Lankan government carried out a programme funded by the IPPF on the social marketing of contraceptives, the situation was completely reversed. As a result of this programme, the Pill was re-branded as *Mithuri* (female friend) and became available as an over-the-counter drug. While the shift from *vanda pethi* to *Mithuri* removed the ethnic connotation attached to the Pill, it also put women's bodies at risk as *Mithuri* could be easily accessed without prior medical examination. I seek to examine how this shift manipulated state policy on health, and what this shift says about women's health and bodies after independence.

SRI LANKA'S ROLE IN THE GLOBAL PILL TRIALS

The story of the Pill in Sri Lanka commenced with a chance encounter between Dr Siva Chinnatamby and Dr Gregory Pincus. They met in Delhi in 1959 at an international conference on family planning and population control organised by the IPPF. However, this was not actually the chance encounter it may first have appeared. At this conference, Dr Pincus from the Worcester Foundation for Experimental Biology in Shrewsbury, Massachusetts, presented a new invention—the Pill. This invention was the collective effort of Dr Min-Chueh Chang of the Worcester Foundation and Dr John Rock, an obstetrician-gynaecologist at the Harvard Medical School.³ Although the invention of the Pill was a collective effort, out of 15 pro-gestational compounds, it was Pincus who decided on norethynodrel with 1.5 per cent mestranol as the oestrogen component.⁴ Hence, he was given the honour of presenting the novel findings of their team at the conference in Delhi. Chinnatamby attended this conference in her capacity as the medical director of the FPA. She was considered the most suitable representative from Sri Lanka as the Government of Sri Lanka had not yet adopted family planning in its agenda.

At the conference, Chinnatamby asked Pincus to assist her in starting a trial of the oral contraceptive pill in Ceylon as she had been dismayed by the fact that ‘activities in this field at home had almost come to a standstill.’⁵ According to Chinnatamby, in the late 1950s there were numerous reports of practical difficulties encountered, particularly in the slum areas of Ceylon, with existing methods of contraception, that is, diaphragm, spermicidal jelly, foam tablets and cervical cap. This was due to the lack of privacy for women who had to use common toilets, etc. Also, there were difficulties associated with the care and storage of diaphragms, namely protecting them from crows when drying in the sun and keeping out of the reach of children.⁶

As a family planner, Chinnatamby saw the Pill trials as a realistic solution to all the practical difficulties faced by women at home. However, the important question was: Would the inventors of such a revolutionary scientific technical fix in the US accommodate a request made by the medical director of a family planning association in a tiny country like Sri Lanka?

In order to answer this question, I must first provide a brief outline of the invention of the Pill at the Worcester Foundation in Massachusetts; the early Pill trials in Puerto Rico, ‘the most studied “underdeveloped” area of the world’; and the intricacies of conducting Pill trials in various other parts of the world.⁷

THE INVENTION OF THE PILL AT THE WORCESTER FOUNDATION

Apart from the three scientists that I mentioned earlier, there were two energetic women who encouraged and funded the Pill trials—Margaret Sanger, the founder of Planned Parenthood of America who had an unstinted belief in the oral contraceptive, and Katherine McCormick, the financial supporter of the Pill.⁸

Min-Chueh Chang, when working on in-vitro fertilisation in 1951, discovered that injecting progesterone could prevent ovulation in rabbits. John Rock, experimenting with the effect of progesterone and oestrogen on ovulation and female infertility, discovered that these two hormones could not only be used as an inhibitor but also as a contraceptive. After much

discussion, Chang, Rock and Pincus began to search for pro-gestational and oestrogen compounds that would be suitable as contraceptives.⁹ Finally, the Pill was patented as 'Enovid' in 1959 and approved by the Food and Drug Administration (FDA) of America the following year.¹⁰ Soon after the invention of the Pill, the team became concerned about its possible carcinogenic effects and decided to include Pap smear testing as a crucial segment of the Pill trials in order to detect cervical cancer.

Since contraceptive research was still illegal in Massachusetts in 1954, 'the Pill team could not conduct large-scale human trials at the beginning,' notes Lara Marks.¹¹ Furthermore, finding 'suitable research subjects who would be willing to follow complicated rules and undergo intense scrutiny and sometimes even surgical investigation' was very difficult.¹² In her letters to Sanger, McCormick described finding women for the trials a 'headache'.¹³ After much discussion and deliberation, the Pill team decided to conduct human trials in New York, Puerto Rico, Japan, Hawaii, India and Mexico.¹⁴ At this stage, Sri Lanka was not on their minds as a possible site for human trials.

THE EARLY PILL TRIALS

Successful human trials were finally carried out in Rio Piedras, a suburb of San Juan (a new housing project) in Puerto Rico in 1956. The Pill 'Enovid', produced by G.D. Searle & Company, was used in these trials. Although the Pill team originally intended to conduct trials in India, they changed their plan and settled on Sri Lanka as a site for trials. Why? Did India not agree? Were large-scale human trials not feasible in India? Did the team opt to drop India once Ceylon, India's closest neighbour, volunteered?

According to Lara Marks, while Pincus' Pill was being developed at the Worcester Foundation in Massachusetts, Dr S. N. Sanyal at the Calcutta Bacteriological Institute in India was testing an oral contraceptive in 1949.¹⁵ It was manufactured from the oil of the plant called the *Pisum Sativum Linn*, the common field pea in India. The contraceptive ingredient was metaxylohydroquinone.¹⁶ Sanyal's experiment was funded by the American philanthropist Dr Clarence Gamble (heir to the Proctor and Gamble soap company fortune). Gamble's mission was 'to find a cheap contraceptive to control the population of the less developed areas of the world'.¹⁷ His

correspondence with John Rock confirms that Pincus did not want to interfere with Sanyal's contraceptive ingredient—metaxylhydroquinone. Further, Pincus doubted the scientific basis of the experiment.¹⁸ Nevertheless, Gamble became confident of Sanyal's experiments after one of his friends from California did a 'Sherlock Holmes job' for him on Sanyal's trials and verified that the researcher was doing a good job.¹⁹

Though Pincus did not want to interfere with Sanyal's Pill, he was still interested in conducting human trials in India as agreed by the Boston team. The Boston Pill team attempted to launch a trial in India by informing Lady Dhanwanthi Rama Rau, the founder president of the FPA of India, of the success of the Pill experiments. In January 1956, Pincus wrote to Rau: 'The results are extraordinarily uniform and so encouraging that we are planning to go ahead with field trials. The amount of material which is available for testing is at present rather limited, but I may be able to secure enough for tests in India.'²⁰ There is no record of her reply.²¹ Nevertheless, a month later, Pincus approached Dr John B. Wyon, field director of the India-Harvard-Ludhiana Population Study (commonly known as the Khanna study) to check the possibility of testing one of the two newer oral contraceptive substances used in his project.²² However, his request was declined on the 'grounds of safety and effectiveness of the substance'.²³

Further attempts to involve India took place in October 1957 when Gamble approached Dr Leroy Allen, a representative of the Rockefeller Foundation in India and former head of public health at the Christian Medical College in Vellore in the state of Madras.²⁴ After discussing the matter with Colonel Raina, the family planning officer at the Ministry of Health, Dr Allen wrote back to Gamble in April 1958 that India was 'unlikely to authorise the import of any of the steroids which inhibit ovulation at this time' and was of the opinion that there was 'insufficient information at hand to certify their safety and long term effect'.²⁵ Referring to the correspondence between birth control giants, Rebecca Williams points out that 'the Gandhian legacy' faithfully upheld by Indian officials in the Ministry of Health in the early 1950s 'did not leave space for any form of contraception other than the rhythm method'.²⁶

All evidence points to the fact that the Indian government rejected all requests of the Boston Pill team to conduct Pill trials in India. The

government was unwilling to subject women to clinical trials when the safety and long-term effect of the Pill were yet unknown. It was then that the Boston Pill team turned to Sri Lanka. In 1959, Sri Lanka volunteered to take up the trials, which subsequently commenced in 1961. Dr Chinnatamby's invitation provided an ideal opportunity for the Pill research team to implement clinical trials in Asia considering the similarities between Sri Lanka and India with respect to culture, religion and traditions. As I have outlined in Chapter 2, Sri Lanka was well-known as a social laboratory by social scientists across the world from the 1960s.

Once Pincus agreed to shift the trial setting from India to Sri Lanka, Chinnatamby visited the Worcester Foundation in Massachusetts, Puerto Rico and Haiti as a guest of Pincus.²⁷ She spent three months in Pincus' unit in Boston studying the Pill trials. On her return to Sri Lanka, she was convinced that the Pill was as much the 'answer to our women of lower socio-economic background as it was for those in the West Indies'.²⁸ Chinnatamby's statement clearly demonstrates her eugenicist motives to plan the unplanned families of the destitute in Sri Lanka.

In October 1961, the Pill trials started in Colombo under Chinnatamby's supervision at the family planning clinic of the De Soysa Hospital for Women, where she worked as a consultant. In spite of the trials commencing in October, it took six months for Chinnatamby to enrol the first 50 women.²⁹ Finally, by 1964, 2,528 women were enrolled for clinical trials. In this cohort, 49.7 per cent of the participants fell into the lower income category, earning less than LKR 100 (approximately 50 pence) per month.³⁰ The Pill was offered free of charge to women who registered for the trials. Chinnatamby explained that a team comprising a 'social worker, midwife, nurse and house surgeon together with the consultant' carried out the trial.³¹ The information provided to women participants of the Pill trials and their economic status show that they were destitute and had limited education. In Chinnatamby's words, 'individual instructions on its use was given to each user by the nurse, house surgeon and myself. Leaflets were distributed to the potential users of the Pill and charts were displayed indicating the details of the regimen of taking it'.³²

According to the assistant medical director of G.D. Searle & Company, the first trial Pills used on Sri Lankan women were 2.5 mg tablets of 'Enovid', given cyclically.³³ According to Chinnatamby, 'every woman in

the trial underwent a routine pelvic examination, examination of breasts, recording of blood pressure and estimation of body weight etc.³⁴ Since the trials were progressing at a disappointingly slow pace, she invited Pincus to 'come to Ceylon and assist her in the trial'.³⁵ He arrived on 7 March 1962 and delivered several lectures to scientific organisations and private groups in Colombo.³⁶ Later on, the trials included many types of oral contraceptives, containing different progestogens and varying doses of oestrogen supplied by 'Searle & Company, Organon, British Drug House, London Rubber Company and Wyeth International and Schering', as arranged by Pincus.³⁷

It is important, at this stage, to provide a brief background of Dr Siva Chinnatamby, the key person who carried out the clinical trials at the De Soysa Hospital for Women, in order to understand how and on what grounds these trials were conducted in Sri Lanka. Analysing the motives and objectives of different personal affiliations and institutions and how they worked, bargained and negotiated will be useful in order to further understand the planning ideology of the late 1950s and early 1960s, which revolutionised the monitoring of women's bodies.

DR (MISS) SIVA CHINNATAMBY (1921–2000)

Dr Siva Chinnatamby's encounter with Pincus and her affiliation with the De Soysa Hospital for Women—the premier government maternity hospital—paved the way for the clinical trials of the Pill in Sri Lanka. Given her family, educational and professional background and exposure, it is not surprising that she took 'a great step forward in medical science in Sri Lanka'.³⁸ She was a modern woman who believed in scientific inventions and had the courage to apply them to support Sri Lanka's pursuit of development in the 1960s.

Siva Chinnatamby was born in 1921 in the northern city of Jaffna—the political and cultural centre of Jaffna Tamils. She belonged to a wealthy Jaffna Hindu Tamil *Vellala* family.³⁹ She was educated at the Ramanathan College for Girls in Chunnakam, Jaffna. Her father was Gate Mudliyar K. Chinnatamby, a government servant in the colonial administration.⁴⁰ She was the youngest of five children. Both her elder sisters died in their early twenties after giving birth to their first born.⁴¹ Although Chinnatamby

belonged to a very traditional family, her educational attainments and social status paved the way for her to be independent, disregarding the social norms of the day. After completing her secondary education at Ramanathan College, she entered the medical faculty of the University of Colombo. She was one of five female medical students out of a total of nine in her batch to qualify as medical doctors. Chinnatamby was the only student to specialise in gynaecology.⁴²

Chinnatamby's first experience in obstetrics started in 1947 when she took up the post of house surgeon at the De Soysa Hospital for Women in Colombo.⁴³ After completing her post-graduate training in the UK, she returned to Ceylon in 1953 and was appointed as a consultant at the same hospital.⁴⁴ She was also appointed as the medical director of the FPA of Ceylon, a post she held for 25 years.⁴⁵ She accepted the latter position only on the condition that she be allowed to practice her speciality—infertility. This was a rather unusual speciality to have in the 1950s, particularly in the field of family planning in one of the most populated regions of the world. In the early 1960s, she directed clinical trials of the Pill and intra-uterine devices, and worked towards creating 'a momentum for family planning as a health activity in Sri Lanka.'⁴⁶

Even though Chinnatamby retired from government service in February 1965, she carried on with the FPA's work in an honorary capacity and continued her research with international institutions and researchers.⁴⁷ Apart from her affiliations with the De Soysa Hospital and the FPA, she also carried out a private practice at her residence in Colombo 7, where she catered exclusively to upper-middle-class women.⁴⁸ She was the main female gynaecologist in the 1960s and 1970s with a clientele from every strata of society.⁴⁹ She was one of the founding members of the Ceylon College of Obstetricians and Gynaecologists established in 1967, and worked as the founder-secretary of the college during its infancy.⁵⁰ She was the first woman in Ceylon to be appointed a Fellow of the American College of Surgeons in 1966.⁵¹ She also served as the president of the Asia and Oceania Federation of Obstetrics and Gynaecology from 1987–89.⁵²

A brief history of the venue—De Soysa Maternity Hospital for Women—will be helpful in order to understand the context in which the clinical trials of the Pill took place in 1961. The De Soysa Hospital for Women plays a rather paradoxical role in the history of the Pill in

Sri Lanka as it was a government hospital that nevertheless became the site for a medical initiative conducted by an NGO. Chinnatamby was the one who brought about this paradox as she was affiliated to both these institutions—the De Soysa Hospital for Women and the FPA.

THE DE SOYSA LYING-IN-HOME

At a time when hospital facilities were still rudimentary in Sri Lanka and the infant mortality rate was 60–65 per 1,000 live births, Sir Charles Henry de Soysa, a philanthropist from Moratuwa (a southern suburb of Colombo), built the first maternity hospital in Sri Lanka by donating a part of his house in Colombo. This came to be known as the De Soysa Lying-in-home.⁵³ The 65-bed lying-in-home was opened on 9 December 1879 by the Governor of Ceylon, Sir J. R. Longden.⁵⁴ By its centennial, the De Soysa hospital had increased its bed strength to 347.⁵⁵ It is now considered the second oldest maternity home in Asia.⁵⁶

Dr A. M. Fernando was appointed the first medical superintendent of the hospital in 1887. The first caesarean delivery in Sri Lanka was performed at this hospital in 1905. It was the premier training institute in midwifery by 1909 and also a training institute for medical students specialising in obstetrics and gynaecology by 1915, and nursing by 1916. It continues to be the foremost training institute for obstetrics and gynaecology even today. In 1921, it housed Asia's first ante-natal clinic. The FPA of Ceylon opened the first family planning clinic, appropriately called 'Mothers' Welfare Clinic', at the De Soysa Hospital for Women on 2 September 1953. By then, Chinnatamby was performing a dual role as consultant at the De Soysa Hospital for Women and medical director of the FPA, an informal welfare organisation founded by a group of elite Sri Lankan women.⁵⁷

With the opening of the 'Mothers' Welfare Clinic' in 1953 and the Pill trials in 1961, the De Soysa Hospital became a site of paradox. Though the government had not yet taken family planning on its agenda, the premier government maternity hospital ended up housing the two most crucial family planning initiatives—the 'Mothers' Welfare Clinic' and the Pincus Pill trials—conducted by the FPA of Ceylon.⁵⁸ As I have pointed out in Chapter 1, the government's stand on family planning was not explicitly put forward until 1965. However, it supported the cause of family planning

in the name of population control, which was seen as a development imperative by the 1950s. The functions of these two institutions (the government and the FPA) merged at some points and diverged at others. Chinnatamby's affiliation to both these institutions made the Pill trials feasible and unproblematic at the De Soysa Hospital. Since the government acknowledged family planning as a development imperative in the name of population control, the Pill trials did not face any difficulties in this arena. Interestingly, an unmarried Tamil female consultant gynaecologist conducted the Pill trials with the aim of contributing to global research on the production of an effective oral contraceptive, in the hope of using this, in turn, to plan the unplanned families of Sri Lanka. For this purpose, Chinnatamby was able to weave the government and the FPA together for the cause of family planning as a development imperative.

Meanwhile, at the global level, it was crucial for the Boston team to conduct Pill trials at different geographic locations in order to minimise the possible side effects and produce the most effective Pill. This became the imperative by late 1962 with the FDA 'receiving reports of twenty six women who had suffered from blood clots in their veins (thrombophlebitis), six of whom died'.⁵⁹ The failure of even one clinical setting to produce results meant a negative impact on the final result and decision of the Boston team. Did Chinnatamby manage to conduct Pill trials according to the criteria set by the Boston team?

THE FAILURE OF PAP SMEAR SLIDES

Pap smear testing is used in clinical trials to detect carcinogenic effects of the studied substance. Pincus arranged to do the Pap smear tests of Sri Lankan women at the Worcester Foundation as Sri Lanka did not have Pap smear testing facilities in 1961. From June 1961 onwards, Chinnatamby was sending smear slides to Pincus for testing.⁶⁰ Chinnatamby claimed in 1964 that there was 'not a single report from Worcester Foundation indicating any complications on Pap smear examinations'.⁶¹ In spite of all efforts, from the correspondence of Chinnatamby, Pincus and Pincus' cytotechnologist, Donna-Drew O'Connell, between 1964 and 1966, it is evident that the smear slides sent from Ceylon were 'unsatisfactory and could not be examined'.⁶²

In January 1964, Pincus wrote to Chinnatamby that ‘it is very sad for us to process a whole batch of slides and find a large proportion of them in such bad shape’.⁶³ In her reply to Pincus, Chinnatamby mentioned a number of reasons and obstacles she had encountered that resulted in the production of poor slides, namely not having the slide containers available on time (they were sent from Boston by post), delays in export permits, port strikes, postal irregularities and the use of the same bottle of lotion for more than one set of slides in order to be more economical.⁶⁴ However, in February 1964 Pincus wrote again to Chinnatamby saying that ‘if the material is properly fixed the slides should be good for a long time’, which suggests that he chose to disregard Chinnatamby’s complaint about the delay in slide containers reaching Ceylon, highlighting instead the shortcomings in the fixing of the slides.⁶⁵ In 1966, O’Connell wrote to Chinnatamby in a rather exasperated tone:

I regret to inform you that, as of this date, this laboratory will not be reading your slides since the fixation is *still* extremely poor. If any new method of fixation is used or the present method is improved, please notify me and we will gladly evaluate the slides.⁶⁶

The stress on the fixation of slides being ‘still extremely poor’ in the letter above clearly demonstrates that Chinnatamby had failed, even after two years (between January 1964 and April 1966), to meet the standards for cytology testing when obtaining Pap smears required by the Boston team. As a result, Sri Lanka could not serve as a full-fledged trial site for the Boston team. It is therefore questionable whether Sri Lanka contributed to the global Pill trials in any meaningful way.

Although Chinnatamby’s efforts in contributing to global Pill trials were not entirely satisfactory, the Pill trials certainly established a link between the FPA and the government. It also paved the way for the government to adopt the agenda of family planning in 1965.

The Pill as the Best Tool for Family Planning in Sri Lanka

In spite of the Pill being available in Sri Lanka from 1961, samples of Sri Lankan women were not tested for any carcinogenic effects since the Pap smear slides sent for analysis did not meet the standards for cytology

testing. However, by 1963, 'the Ceylon Hospital Drug Committee agreed to include oral pills in the Hospital Formulary, disregarding the impending carcinogenic effects of the Pill'.⁶⁷ According to Professor Ranasinghe, the head of the Hospital Drug Committee at that time, there were 14 brands of pills available in Sri Lanka by 1970.⁶⁸ Can we infer that the Ceylon Hospital Drug Committee made the health of Sri Lankan women vulnerable by importing pills (developed by foreign pharmaceutical companies) that were not tested in Sri Lanka for possible carcinogenic effects?

This omission was not surprising considering the articles that appeared in Sinhalese newspapers with reference to the Pill. Questions regarding women's health concerns were never raised by the Sinhalese media, although English newspapers reproduced foreign press reports on the carcinogenic effects and thrombosis associated with the Pill based on research carried out in the United States and Europe.⁶⁹ The Sinhalese newspapers saw the Pill *only* as a weapon and a tool to disturb the ethnic balance of the country; hence, the coinage of the term *vanda beheth/pethi* (sterility pills).

Women's bodies have been and continue to be seen only as reproductive machines important in influencing population growth and census reports, rather than as corporeal entities with their own needs and desires. A woman's health was a matter of concern to the state as long as her reproductive body was in control. The state used the Pill, in line with the dominant planning ideology of the mid-1960s, to plan the unplanned families of Sri Lanka at the expense of women's health.

Furthermore, medical professionals in Sri Lanka encouraged women to use the Pill while evading questions regarding its safety because the Pill seemed an effective method of family planning in Sri Lanka in the late 1960s. Professor Ranasinghe deliberately evaded the question of whether the Pill led to thrombosis by claiming: 'Chances of getting thrombosis during pregnancy are greater because pregnancy itself can bring on thrombosis.'⁷⁰ On the other hand, Sinhalese Buddhist extremists saw the Pill not as a health hazard to women, but as a modern, Western, imperialist tool to reduce the majority race to a minority.⁷¹ Both medical professionals and Sinhalese Buddhist extremists were trying to manipulate women's bodies for their own agendas. As a result, they failed to see the health implications of the Pill for women.

Medical professionals and family planners of Sri Lanka were convinced that the clinical trials and the introduction and delivery of the Pill were a

timely endeavour to plan the unplanned families of Sri Lanka. However, the Sinhalese Buddhist extremists carried out a vociferous discussion on family planning, population growth and contraception linked to ethnicity, development and modernisation in the Sinhala newspapers *Silumina* and *Dinamina* in the late 1960s. Yet, less than five years later, by the mid-1970s, the Pill was re-branded Mithuri (female friend) as a result of an IPPF marketing programme and subsequently became an over-the-counter drug. How should we understand this shift? How did the Sinhalese Buddhist extremists react to this about-turn?

The second part of the chapter examines how women's bodies were manipulated through this shift in terminology from vanda beheth/pethi to Mithuri. Even though the term vanda beheth/pethi is dismissed by today's family planners and gynaecologists, the change in terminology speaks volumes about the way women's bodies were framed within the Sinhalese Buddhist nationalist discourse at this particular moment in the history of independent Sri Lanka.⁷² Vanda beheth/pethi was a derogatory term with a negative connotation in the nationalist discourse, while Mithuri became a positive term with a broader scope in the development discourse. What does this shift suggest? Did Mithuri silence the ethnic connotation attached to the Pill and give it a new image? If so, what happened to women's health and bodies during this silencing process? Did Mithuri silence women's agency in the matter of their health and bodies in the name of development? I shall now probe the nature of this shift by answering these questions. I commence with my first encounter with the term vanda beheth/pethi in Sinhalese newspapers in the late 1960s and examine the different connotations attached to it. Understanding this term is significant to the story of the Pill because it came into being when discourses on women's bodies, for the first time, framed a women's health initiative through the introduction of the Pill in Sri Lanka.

WOMEN'S BODIES AND THE FRAMING OF CONTRACEPTIVE DISCOURSES

I first came across references to birth control pills as vanda pethi (sterility pills) in September 2010, when I was doing archival research at the National Archives of Sri Lanka in Colombo. I discovered that this term had first

been used in 1969 in the *Silumina*, the most widely circulated Sinhalese newspaper of the time.⁷³ I was bemused and bewildered by such a term used for the Pill. I also encountered the term in another Sinhalese newspaper dating from 1970. This article was headlined in bold letters: *Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa: Eya Vahama Nathara Karanna* ['Sterility Pills Will Reduce the Sinhalese Race to a Minority: It Should Be Stopped Immediately'].⁷⁴ Both *Silumina* and *Dinamina* are government-owned newspapers.

The term vanda beheth/pethi made me wonder whether there had been a more colloquial term for the Pill. Nothing came to my mind other than Mithuri (female friend).⁷⁵ I asked my immediate female family members—my mother, mother-in-law and aunts—of another more colloquial term, to which they all answered '*upath palana pethi*', which literally means birth control pills. Then I told them about my archival research finding (vanda pethi/beheth) and to my amazement they were not surprised. My mother-in-law (born in 1942) casually said, 'Oh yes, the Pill was commonly called vanda pethi in our village in those days.' Similarly, my mother (born in 1946) said, 'Yes, I remember, we [meaning her three sisters in their early twenties] used to laugh at *Ananda ayya* [their brother-in-law, who was a medical officer between 1965 and 1970 in a small village in the western province of Sri Lanka] when he used the term vanda pethi when instructing midwives of the area on its use and distribution.' I asked why they had laughed at the term. 'Don't you think it is a very *gode* [unrefined] word to be used by a doctor?' she asked me. 'So did he refine it after you teased him?' I asked, thinking her answer would be in the affirmative. But I was wrong. He had told her that even though vanda pethi sounds gode, that is what it was commonly referred to in Sinhalese so he had to use it when instructing midwives. This anecdote suggests that vanda pethi was the term commonly used for the Pill among the rural peasantry of Sri Lanka in the 1960s.

I checked the usage of vanda pethi with the medical director of the FPA, the director of family planning at the Ministry of Health and the former dean of the faculty of medicine. They all stated very authoritatively that 'the Sinhalese term for the Pill is *upath palana gilina pethi* [oral birth control pills]'. I asked them whether they had come across the term vanda pethi/beheth at any point in their career as medical professionals,

especially when they had served in different parts of the country. They all responded in the affirmative, but then the former dean added, in a rather contemptuous tone: 'Oh! The Sinhalese [meaning extremists] are very good at creating sensational terms.' He sounded as if this negative connotation attached to the Pill was merely an outrageous idea created by extremist Sinhalese nationalists and had no wider influence. The Ministry of Health official described it as 'journalistic rubbish'.⁷⁶ But was it merely 'journalistic rubbish'? A head of department of sociology of a state university also referred to the Pill as *vanda pethi* in an interview given to the *Silumina* in 1969 on whether sex education should be incorporated into the school curriculum.⁷⁷

What do all these anecdotal and archival accounts point to? Undoubtedly, *vanda pethi/beheth* was the Sinhalese colloquial term for the Pill, but today the term sounds repulsive, especially to medical professionals who work in the field of family planning. Is it because they now have a better term, *Mithuri*, to refer to the Pill, or did they disapprove of the link between women's bodies and the proposed ethnic imbalance that *vanda pethi* suggests? As a historian, I am not ready to shrug off *vanda pethi* or *beheth* as 'journalistic rubbish' because for me this intriguing term suggests a vexed connection between Sinhalese Buddhist nationalism, women's bodies, development and modernisation.

Vanda Beheth/Pethi Connotes...

Three implied, interrelated meanings for the term *vanda beheth/pethi* can be seen in the newspaper discussions on contraception. It is important to first smoothen the rough edges of the Sinhalese term for the Pill in order to understand how women's bodies framed the basis of this shift from *vanda beheth/pethi* to *Mithuri*.

First, *vanda beheth/pethi* addressed the literal meaning of 'sterility pills', which is understood in terms of impairing the growth of the population. Sinhalese nationalists viewed the Tamil minority with suspicion as an impending threat to the ethnic balance in the same way that the West viewed increasing populations as a Communist threat during the Cold War in the 1950s. The fear of impending ethnic disproportion was voiced in the Sinhala daily *Dinamina*, giving prominence to numerical aspects

of the population: 'it will reduce the majority to a minority'.⁷⁸ After the Sinhala Only Act of 1956, Sinhalese Buddhist nationalism emerged with a new vigour, supported by Prime Minister S. W. R. D. Bandaranaike's five great forces: *Sangha* (Buddhist monks), *veda* (Ayurvedic physicians), *guru* (school teachers), *govi* (farmers) and *kamkaru* (labourers).⁷⁹ Two of these forces, namely Buddhist monks and school teachers, who were revered as upholders of traditional culture, contributed to the newspaper discussion on contraception with a strong Sinhalese Buddhist chauvinistic outlook. Another force, the Ayurvedic physicians, were organised under the Mithuri programme to take the Pill to the rural masses by the late 1970s. The consequence of the Bandaranaike regime of 1956 was succinctly described by S. Bastian et al. as 'the rapid Sinhalisation of the post-colonial state in a framework of Sinhalese-Buddhist cultural identity'.⁸⁰ This chauvinistic Sinhalisation process was well-documented in newspaper discussions on contraception in the late 1960s.

By the mid-1960s, the state was also attempting to define the development agenda for the Sinhalese Buddhist nation-state. After the assassination of Prime Minister Bandaranaike in 1959, the *Ten Year Plan* (1959–69), which experts claimed was an excellent development plan, did not make as much progress as hoped for. What did development mean for the Sinhalese Buddhist nation of Sri Lanka? The reduction of the population growth rate seemed the most viable way ahead. However, since it was the Sinhalese Buddhist nation and not the wider nation that had to be developed, nationalists described the Pill as *vanda beheth/pethi* to suggest that the Pill should not be taken by Sinhalese Buddhist women (but rather by women of other ethnic groups). In this way, the Sinhalese Buddhist nation should be the beneficiary of the fruits of development born of population reduction. The ethnicity and marital status of the pioneer of the Pill, Dr Chinnatamby, an unmarried Tamil woman, added strength to the claims of Sinhalese Buddhist extremists that the Pill was a weapon to disrupt the ethnic balance of the country.

Chinnatamby as Mother of *Vanda Beheth* in Sri Lanka

What was the impact of the clinical trials of the Pill undertaken by an unmarried Tamil female gynaecologist in a predominantly Sinhalese Sri

Lanka, particularly after the Sinhala Only Act in 1956 and the anti-Tamil riots in 1958?⁸¹ The Sinhala Only Act replaced English as the official language of Ceylon with Sinhala and simultaneously removed the official status of Tamil, the language of the minority community. This move was opposed by Tamils, who requested that Tamil be declared as the administrative language in the predominantly Tamil-speaking northern and eastern regions of the island. This resulted in the Bandaranaike–Chelvanayakam pact of 1957. However, Bandaranaike was forced by Sinhalese nationalists to cancel the pact in 1958, which led to the first island-wide anti-Tamil riots after independence. It is against such a backdrop that Sinhalese nationalists sought to cast suspicion on the link between Chinnatamby's ethnic identity and the oral contraceptive introduced by her, which they perceived as a weapon to make Sinhalese women sterile.⁸²

But why should Chinnatamby not involve herself in clinical trials? As previously mentioned, she was the medical director of the FPA who had attended the IPPF conference in Delhi and met Dr Pincus. Considering her official position, she was the most suitable person to launch such an initiative. Furthermore, her affiliation with the premier government maternity hospital—the De Soysa Hospital for Women—provided her with a perfect location to conduct the clinical trials of the Pincus Pill. Indeed, this undertaking was a medical victory in the eyes of the family planners and medical professionals of Sri Lanka. It is clear from my interviews with Chinnatamby's colleagues that they harboured no doubts concerning her decision to take up the Pill trials. Chinnatamby's successor at the FPA saw it as a 'great step forward in medical science in Sri Lanka'.⁸³ The former dean of the faculty of medicine and one of Chinnatamby's students in the early 1970s observed that she created a 'momentum for family planning as a health activity in Sri Lanka'.⁸⁴ She is fondly remembered by contemporary medical professionals in Sri Lanka as the 'Mother of the Pill'.

Chinnatamby's upper-class family background, education (alumna of Ramanathan College in Jaffna), profession (gynaecologist) and international exposure enabled her to become a capable and competent woman worthy of undertaking a modern scientific project such as the Pill trials. Her voluntary effort in conducting Pill trials could be best analysed through Scott's concept of 'high-modernist ideology', which he defines as:

[A] strong sense of self confidence about scientific and technical progress, the expansion of production, the growing satisfaction of human needs, the mastery of nature (including human nature), and above all, the rational design of social order commensurate with the scientific understanding of natural laws.⁸⁵

In the late 1950s, Chinnatamby was dismayed by the practical difficulties of existing methods of contraception, and as the medical director of the FPA she had identified that the time was ripe to introduce a modern contraceptive method to Sri Lanka.⁸⁶ Pincus' Pill trials came about at a moment when Sri Lanka was in need of a modern, scientific and technical solution for existing problems in family planning activities. Chinnatamby thus saw the Pill as the best scientific invention to 'master' the human nature of reproduction by planning the unplanned families of Sri Lankans in order to turn the country into a development 'model' for South Asia. At that time, Sinhalese Buddhists portrayed Chinnatamby as someone attempting to disturb the ethnic balance of the country by using vanda beheth/pethi as a weapon. However, when delving into the historiography of the Pill trials in Sri Lanka, it becomes evident to me that the question at stake was not Chinnatamby's ethnicity, but women's health. The real issue at stake was the jeopardy that market forces placed women's health in with the conceptual shift from vanda beheth/pethi to Mithuri. I will deal with this question in the next section after analysing the other two connotations of vanda beheth/pethi.

The first connotation addressed the quantitative aspect of population, while the second refers to the qualitative aspect, which links culture, morality and civility. Vanda beheth/pethi was the perceived instrumental reason for the degeneration of the Arya Sinhalese Buddhist race as it allowed people to indulge in carnal pleasures while enabling them to escape their moral obligations and responsibilities towards the nation.⁸⁷ This weighed heavily on women, as I have pointed out in my introductory chapter; it was the women's duty to uphold tradition, inculcate good morals in children and regenerate the nation. The view expressed by both the Buddhist and the Catholic clergy was that 'married life is not merely having pleasure in the sexual act but is a great responsibility which requires self-restraint and self-discipline, only then can a nation with high moral values develop.'⁸⁸ The chief prelate of the Sri Amarapura Dhammarakshita

Nikaya⁸⁹ and one of the most vociferous monks of the day, Madihe Pagnaseeha Thero, were predicting in 1969 that the vanda pethi would make Sri Lanka a sterile civilisation in 25 years.⁹⁰ By calling the Pill vanda beheth/pethi, these Sinhalese Buddhist extremists not only intended to reduce the number of people using contraception but also hoped to prevent people from indulging in carnal pleasures. For example, Professor Siri Seevali Thero (former dean of the Buddhist faculty at Vidyalankara Pirivena in 1969) openly advocated that the best method of birth control was sexual abstinence. He further explained that other birth control (*upath palana*) methods which prevented women from conceiving (*upath valakveemaki*) were not acceptable according to Buddhist philosophy.⁹¹

A renowned sociologist noted in the 1960s that '[i]t is very important for the youth to be aware of sexual activities, in order to lead a happy married life. Then *sterility pills* are not needed for population control, it only makes women promiscuous.'⁹² What does this statement suggest? It suggests that the Pill was perceived as an agent of immorality and corruption that would transform the Sinhalese Buddhist nation into an uncivilised state. In other words, some saw the Pill as a licence for women to be free from traditionally and culturally disciplined bodies.

The third connotation of vanda beheth/pethi was the repugnance of nationalists of the 1960s for the Pill, which they viewed as a modern Western product. This led to its violent refusal as nationalists abhorred anything originating in the West. Thus, by using the term of abhorrence, vanda beheth/pethi, they sought to keep the Pill (a Western product) out of the 'inner' domain or 'spiritual essence' of the nation. When the Pill was introduced in 1961, the FPA was severely criticised by the Sinhalese Buddhist nationalists for being an organisation set up by Westernised women in order to corrupt Sinhalese Buddhist culture. Madihe Pagnaseeha Thero called the FPA a 'devious organisation' (*Koota Vyaparayaki*), established by a handful of upper-class Catholic women to make the Sinhalese Buddhists a minority.⁹³ He considered the FPA a counterfeit organisation framed within modern Western thinking, working towards making the Sinhalese race extinct in Sri Lanka. In the 1960s a virulent nationalist discourse permeated the public health system through the malaria control programme; thus, vanda pethi should be understood as part of this extreme nationalist discourse. Malaria-endemic Dry Zone

(referring to the *Rajarata* civilisation, meaning the civilisation of the kings' country) was a high priority national development goal in the 1960s, inspired by the nationalist vision of restoring the ancient glory of a Sinhala-Buddhist civilisation.⁹⁴ The impending extinction of the Sinhala race through vanda pethi gained momentum within such a political milieu.

The premise of these three connotations—the quantitative and qualitative aspects of population and the repugnance it gave rise to—was the overarching theme of nationalism which had and continues to have an intrinsic link with women's bodies in Sri Lanka as the site of national and cultural reproduction. Having set out this link, I will now examine the shift from vanda beheth/pethi to Mithuri. How did the Pill that was once contemptuously rejected as vanda beheth/pethi become a woman's female friend or Mithuri in less than half-a-decade?

FROM VANDA BEHETH/PETHI (STERILITY PILLS) TO MITHURI (FEMALE FRIEND)

Vanda beheth/pethi was renamed Mithuri in 1974. This was the result of an active social marketing programme for contraceptives—a programme commissioned by the IPPF and conducted by Population Services International, Sri Lanka. From that time onwards, any oral contraceptive distributed through the public health sector was commonly referred to as Mithuri, despite a variety of different brands being available in the market. Mithuri is now marketed exclusively by the FPA of Sri Lanka.

In 1969, the concept of social marketing was applied for the first time in the world to contraceptives with the marketing of the Nirodh (meaning 'prevention' in Sanskrit) condom in India.⁹⁵ The second largest brand of condoms, Raja (King), was launched in Bangladesh in 1974. Jamaica launched a social marketing programme for both condoms and oral contraceptives.⁹⁶ According to LaCheen, at least 27 developing countries were implementing projects for the marketing of contraceptives by 1980.⁹⁷

Influenced by the global trend of social marketing of contraceptives, Population Services International with the support of the FPA launched the marketing of the condom brand *Preethi* (joy/happiness) in May 1973 and the oral contraceptive Mithuri (female friend) in December 1974.⁹⁸ As a result of this programme, the Pill became widely accepted both by the Sri

Lankan medical community and the general public. Eugynon ED Fe (each tablet contained 0.5mg of dl-norgestrel plus 50 µg of ethinyloestradiol) was imported from Bayer Shering Pharma in Germany and re-branded Mithuri (female friend). The name Mithuri helped to establish the Pill as the intimate female friend of Sri Lankan women.⁹⁹

Sri Lanka did not limit itself to a re-branding programme. An additional nation-wide mail-order distribution system was set up, through which women received promotional literature by post along with an unsigned prescription for the Pill.¹⁰⁰ Doctors were duly instructed to sign this pre-printed prescription that patients brought along. With the IPPF's introduction of this new marketing strategy to Sri Lanka, the clinic-oriented family planning programme shifted to retail shops. Shops were 'more convenient than clinics to the customers as they were open for longer hours, were devoid of formalities, and strict clinical routine hours of work'.¹⁰¹ According to a survey conducted by the FPA on dealers of contraceptives, by 1981 Mithuri was sold at three types of establishments: drug stores and pharmacies, general stores and groceries, and restaurants and tea rooms.¹⁰² This suggests the presence of the nascent market forces which had been encroaching on Sri Lanka with the shift towards economic liberalisation from 1977. I will discuss in detail the impact of neoliberal market forces on women's health and bodies in Sri Lanka in Chapter 4. At this juncture, I will concentrate mainly on those nascent market forces that manifested themselves through the social marketing campaign of Mithuri.

Though paper advertisements of Mithuri did not appear till 1976, private practitioners and chemists advertised it through aluminium wall plaques, leaflet holders and glass-topped counter displays.¹⁰³ This was a very effective marketing strategy and Mithuri became indeed a dear friend to many women and a common household name by the late 1970s.¹⁰⁴ Was it the state's intention to erase the ethnic connotation attached to the Pill by cementing the relationship between women and Mithuri? This intimate relationship was further strengthened by two family planning policy decisions adopted by the government—the National Pharmaceutical Policy of Sri Lanka formulated in 1971 and the training of traditional Ayurvedic physicians to promote family planning in 1975.

The Pharmaceutical Policy of 1971 did not resist the market forces that were creeping into the health sector through Mithuri. The training of

Ayurvedic physicians to promote family planning was an attempt to reach the grassroots. Both these policy decisions facilitated the elimination of vanda beheth/pethi's ethnic attire, replacing it with a modern, development attire—Mithuri. How did women's bodies react to this new profiling? What was really at stake in the incorporation of the two policy decisions mentioned earlier? Let me answer these questions through an analysis of these two policies.

PHARMACEUTICAL POLICY OF SRI LANKA (1971)

Sri Lanka was one of the first countries in the world to come up with a National Pharmaceutical Policy, in 1971. The main aims of the policy were to reduce the number of drugs in the market, promote the prescription of generic names of drugs in both the private and the public sector, create a state purchasing agency for the whole country, expand drug production in the country and increase the provision of adequate information on drugs.¹⁰⁵ How did the Pharmaceutical Policy of 1971 respond to the re-branding of Eugynon ED Fe as Mithuri? How was it possible for Eugynon ED Fe to shed its generic name and adorn itself in a marketable name, Mithuri? I will provide a brief history of the formulation of the National Pharmaceutical Policy in order to understand why and how Mithuri was exempted from the rules laid down by this policy in 1974.

Drug supply problems emerged during Prime Minister S. W. R. D. Bandaranaike's regime, in 1958, due to financial constraints faced by his government. As a solution to this, the Ceylon Hospitals Formulary was drawn up to decide which essential drugs should be made available in hospitals. This can be considered part of the Sinhalisation programme of the Bandaranaike regime. In 1971, during Mrs Bandaranaike's regime, this initiative was carried forward by Senaka Bibile, professor of pharmacology and dean of the faculty of medicine, University of Peradeniya, and Dr S. A. Wickremasinghe, medical doctor-cum-leftist politician. They formulated the National Pharmaceutical Policy of Sri Lanka by rationalising pharmaceuticals and ensuring that 'drugs are available for those who need them in adequate quantities and at reasonable prices'.¹⁰⁶ The aim of the policy was to 'use limited resources to maximize drug availability by limiting drug purchases to the smallest number required for effective

coverage of each category of action'.¹⁰⁷ The National Pharmaceutical Policy of Sri Lanka was used as a model for other countries to formulate their national policies on pharmaceutical use in the early 1970s.

In order to limit the number of drugs in the market, the National Formulary Committee reviewed 4,000 drugs (6,000 dosage forms) and decided to reduce the number to 2,100 (3,000 dosage forms).¹⁰⁸ Needless to say, there was much opposition to these reforms from the global pharmaceutical industry and their agents in Sri Lanka. However, in 1971, the State Pharmaceutical Corporation of Sri Lanka (SPC) was established as the state buying agency, and Professor Bibile was appointed its founder-chairman.¹⁰⁹ Moreover, the National Pharmaceutical Policy stipulated that drugs could only be prescribed by their generic names, not trade names, while advertising drugs was strictly prohibited. However, Mithuri did not abide by either of these clauses.¹¹⁰ Davies reminds us that according to the law at the time, only licensed doctors could prescribe, and only they and licensed chemists could distribute oral contraceptives.¹¹¹ Then why was Mithuri exempted from the pharmaceutical policy?

The initiative to formulate a pharmaceutical policy for Sri Lanka first came into being under the socialist-oriented government led by Mr Bandaranaike in 1959. The policy was adopted in 1971 under another socialist government headed by Mrs Bandaranaike. Most importantly, the architects of the policy were members of the *Lanka Sama Samaja* Party, which followed a Marxist ideology with socialist aims. The aim of the socialist government in the early 1970s was to provide a good healthcare system by reducing the cost of drugs without compromising their quality, in the hope of developing a nation of healthy citizens and cultivating an autonomous national identity. However, the same socialist government did not interfere (even though the National Pharmaceutical Policy was in effect) with the FPA's social marketing of contraceptives—the Mithuri programme. The Pill was promoted as an over-the-counter drug in 1975. Reasons given by the Population Services International were that: 'The shops through which we reach people who want contraceptives cost us nothing.... In contrast, clinics and health centres (aside from being relatively few in number) are very expensive to build and operate.'¹¹² What were the consequences of making the Pill available over the counter? It provided women free access to the Pill without medical prescriptions or

undergoing medical examinations to ascertain whether their bodies would find the Pill compatible. Unrestricted, easy access to contraceptives implied that women were able to enjoy greater autonomy over their bodies. The question here is: Who was holding the reins of power and autonomy in such a situation—women, the state or the market?

Emphasising the easy accessibility of Mithuri, a Member of Parliament opined at a seminar on population and development, held in Colombo in March 1980, that women will

save the time and the embarrassment of queuing up in clinics and other places where midwives and other health officials doled out pills....They have only to go round the corner and buy their requirements from the nearest boutique.¹¹³

He seemed to be rejoicing in women's empowerment and their control over their bodies through Mithuri. However, I feel that having easy access to the Pill did not necessarily mean that women were in control of their bodies, especially within the Sri Lankan context. The danger of easy accessibility was that Mithuri could be consumed without a medical examination, regardless of its suitability for individual women. One could argue that since there were no reported deaths caused by Mithuri in Sri Lanka, it did not pose a threat to women's health. However, in Sri Lanka, unlike in the West, there was no procedure to investigate the cause of death from any sickness, including cancer, in the 1980s. Thus, having easy access to *Mithuri without a medical examination* did not necessarily mean women's empowerment.

On the one hand, both politicians and medical doctors favoured Mithuri being taken off the list of prescription drugs. According to Davies, one of the doctors on the Mithuri programme clearly admitted his time constraints when he noted: 'I'll gladly sign the prescriptions, but you should take the Pill off prescription since none of us have time to examine the women anyway.'¹¹⁴ His attitude clearly signifies that the Pill was and continues to be considered by medical doctors, family planners and development workers as a mechanism for birth control, rather than as an issue of an informed choice for Sri Lankan women.

On the other hand, the state was facing a dilemma with regard to the Mithuri programme. The state could not challenge the Mithuri

programme, even though it did not abide by the National Pharmaceutical Policy, since it was catering to the control of the population growth rate, which was seen as a greater national need. Here, women's health and bodies were sacrificed to market forces in order to support the development dream of the state. Unfortunately, the National Pharmaceutical Policy designed to protect the health of the nation from market forces failed to protect the health of women when these forces appeared in the guise of a female friend—Mithuri. Were Sri Lankan women empowered through the Mithuri programme? Given the facts above, it is evident that it was neither women nor the state holding the reins of power; rather, it was the market. The state permitted the market to 'access' its inner domain—the family—through the Mithuri programme. Then, can we still consider Mithuri an empowering agent for women?

The Mithuri programme not only made the Pill an over-the-counter drug but also reached out to villagers through advertising. After 1977, Mithuri advertisements conjured up an intimate rural scenario with a happy couple in rural attire with the wording, 'because of love...' (Image 3.1).¹¹⁵

A vigorous family planning campaign was carried out by the Ministry of Plan Implementation in the 1980s through the introduction of new slogans such as *Punchi Pavula Raththaran* ('a small family is golden'). This slogan was painted on lottery sales carts that travelled to rural areas promoting the state lottery, *Sanvardana Lottarayiya* ('Development Lottery').¹¹⁶ These lottery carts captured the development ideology of the state very succinctly; a small family (*punchi pavula*) with a mother, father and two children was considered an ideal family. Bordo's 'self-policing subjects' were created through these images and slogans.¹¹⁷ By depicting a happy couple, the advertisement in Image 3.1 shows that the 'self-policing subject' was created in both the woman and the man.

By the late 1970s, FPA adopted further rural images in their advertisements to promote family planning among villagers.

An advertisement, titled *Ganga Langa Kathawa* ('Talk by the River') (Image 3.2) shows two women exchanging information on family planning while having a bath in the river (upper-most box). The next day, one of the women, who is pregnant, shares with her husband the knowledge she had gleaned from her friend (box on the left). Once the baby is born, the

Image 3.1. Mithuri Advertisement, 'because of love...'



because of love....

Now you are together... united by love... sharing a dream. Two happy people ready to build a home. A home filled with the musical laughter of adorable children. Love is the basis of all these beautiful things.... your love for each other and your love for your children.

It is also love that makes you space your children. So that you have all the time and means to care for them. Today, thinking people like you use Mithuri - the simple, safe oral contraceptive.... Because of love.

Ask your Doctor for advice on Mithuri



Mithuri the oral contraceptive for women.

de Alwis

Source: *Sunday Observer*, 19 August 1979, p. 6.

Image 3.2. 'Ganga Langa Kathawa' (Talk by the River) (advertisement).

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කැ.පෙ. 365, 37/27, පුලුස් පවුල, පොලොම් 7, දුරකරනය: 84203.

රි. කිසිම

ලේ ක්කවුක්

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Source: Dinamina, 13 August 1977.

husband brings information on family planning methods obtained from the FPA and says, 'Let's discuss family planning once you read all this information' (box on the right). At the very bottom of the advertisement, there is a statement by the FPA: 'In order to lead the family towards progress, husband and wife must discuss and plan their families.'¹¹⁸ The idea of progress and development through family planning was the key message that the family planning programme promoted in the late 1970s. By inviting the woman to read the information leaflet on family planning, the advertisement shows that the man has also become a 'self-policing subject'.¹¹⁹

As mentioned in Chapter 2, Ayurvedic physicians were called upon for the first time in 1975 to take the Pill to the rural masses. Dr Malcom Potts, director general of the IPPF in 1974, shared the reason for this unusual move by saying that an Ayurvedic physician has 'a skill with people that the Western doctor often lacks'.¹²⁰ The ideological change initiated through the social marketing programme of contraceptives was rejuvenated by incorporating Ayurvedic physicians into family planning activities.

INCORPORATING AYURVEDIC PHYSICIANS INTO FAMILY PLANNING ACTIVITIES

The second policy decision taken by the state to cement women's relationship with Mithuri was to train Ayurvedic physicians in family planning activities. Dr Malcom Potts begged these traditional physicians who were first trained in family planning in 1975: 'Please help us. Please take the Pill we have invented and tell us how to distribute it.'¹²¹ At his request, traditional Ayurvedic physicians were mobilised to take the Pill into rural areas. How did the government manage to get one of Bandaranaike's five forces of Sinhala nationalism to distribute the modern Western Pill to the rural masses? More importantly, how did an Ayurvedic physician who upholds traditional culture introduce a modern Western technological invention (once seen as an anathema, *vanda beheth/pethi*, by Sinhala nationalists) to the rural masses?

The traditional and Western medical systems were rarely in dialogue on subjects such as family planning and contraception. Family planning was perceived as an entirely Western medical and development issue until Dr

Malcom Potts called upon Ayurvedic physicians to introduce the Pill to the rural masses at the First International Scientific Congress of the FPA held in Colombo from 21 January to 26 January 1974.¹²² This suggestion was reiterated in the evaluation report written by one of the doctors involved in the Mithuri marketing programme: 'Why don't you let the indigenous physicians [Ayurvedic physicians] dispense the Pill also. They are even closer to the masses than we are and have greater influence.'¹²³

By 1974, there were around 16,000 registered Ayurvedic physicians in the country.¹²⁴ Since Ayurvedic physicians seek to uphold traditional culture, they did not have a favourable attitude towards family planning as it was considered a modern Western concept. In spite of this, the department of health launched a training programme, funded by the IPPF through the FPA, to enrol Ayurvedic physicians to participate in the family planning effort.¹²⁵ Initially, 25 Ayurvedic physicians were trained, but by the end of 1975, 165 were engaged in promoting family planning in their areas.¹²⁶ By 1977, there were 800 Ayurvedic physicians promoting family planning.¹²⁷ The training of these physicians was complemented by an increase in the retail outlet base of oral contraceptives in 1978.¹²⁸

It was indeed a strategic move by the IPPF to use the traditional medical system to promote a modern family planning technology, because that proved to be the best way to reach the rural masses. The IPPF was able to make ideological inroads into the 'inner' domain of the nation through these Ayurvedic physicians as well as retail outlets. Mithuri thus became a bosom friend of Sri Lankan women with the blessings of both the Western and the traditional medical systems.

The government distributes 30 micrograms of ethinyl oestradiol and 150 micrograms of levonorgestrel obtained from WHO pre-qualified manufacturers who are on the procurement list of the UNFPA. These pills are distributed free of charge or 'doled out'—as one government minister had put it—by government family health workers in accordance with the 'free health policy' of the government. Women who can afford to buy Mithuri ingest it without undergoing a medical examination to assess its suitability for their bodies. This raises the question of whether Mithuri is truly a woman's friend. Does it offer women an opportunity to understand and take control of their bodies, as Sanger envisioned in the 1950s?¹²⁹

When considering the Sri Lankan situation, the liberating and emancipatory aspect of the Pill has become a double-edged sword. On the one hand, the availability of and free access to the Pill gives women the possibility to control their own fertility and reproductive cycles. On the other hand, taking the Pill without medical examination means it could be detrimental to women's health. There is a possibility that the Pill would increase the risk of heart disease.¹³⁰ Even though women's bodies were liberated from reproducing because of the wide availability of and easy access to the Pill, women's health was put at risk by depriving them of medical examinations.

From medical professionals and family planners' point of view, Mithuri was the perfect answer to keep up the replacement-level fertility already achieved in 1994, and its free availability exemplifies women's empowerment in Sri Lanka. However, free availability of Mithuri through liberal market forces jeopardised women's health. In other words, what does it mean to have liberal access to the Pill without any medical examination? I argue that Mithuri empowered women to have control over their reproductive bodies, but at the cost of their health.

The birth control pill is considered the first lifestyle drug of the twentieth century. This was a pill for healthy women; not to treat any disorder or discomfort. It meant different things to experts from various fields. For demographers, it was a tool to control the growing population of the Third World. For family planning activists, it emancipated women sexually. For development activists, it was a panacea for chronic underdevelopment. For pharmaceutical companies, it ensured lucrative profits.¹³¹ Further, the Pill marked a moment of negotiation and bargaining with different institutional and social structures and networks in order to invent, conduct human trials and introduce this family planning method first to the American public through the FDA of the United States and then to the world.

Sri Lanka participated enthusiastically in the global contraceptive debate as a laboratory site for Pill trials in 1961. This was not a government initiative, but the volunteering effort of an NGO—the FPA of Ceylon—carried out in a government space—the De Soysa Hospital for Women. This amalgam led the government to take up family planning as a national policy in 1965. However, by the late 1960s the Pill had been termed vanda

pethi by Sinhalese Buddhist extremists, fuelled by the ethnicity and civil status of the instigator of the Pill trials, Dr Siva Chinnatamby. By the mid-1970s, vanda pethi was re-branded as Mithuri and became an over-the-counter drug. This shift silenced nationalist sentiments and ethnic tensions by providing a new development outlook to the Pill as Mithuri, but enhanced the health risk for women who received the pills without a medical examination.

The history of the Pill trials and its introduction to Sri Lanka is of special significance for my book as it brings women's health and discourses on the woman's body into a unified analytical framework. As mentioned in the Introduction, my analysis of two significant women's health initiatives of independent Sri Lanka—the introduction of the Pill in 1961 and the launching of the island-wide WWC programme in 1996—marks two key moments in this work. In readiness for the exploration of the second women's health initiative, the WWC programme, Chapter 4 will provide a detailed analysis of discourses on the woman's body in the 1990s, as the Sri Lankan state re-defined and mobilised women and their bodies in particular ways as a response to the economic and political turmoil it experienced.

NOTES

1. An abridged version of this chapter was published as 'Birth Control Pill Trials in Sri Lanka: History and Politics of Women's Reproductive Health (1950–1980)' in *Social History of Medicine* 33 (1), February 2018, pp. 268–87.
2. Interview with the former dean, Faculty of Medicine, University of Colombo (one of the first students of Dr Siva Chinnatamby at the Faculty of Medicine, University of Colombo, in 1970), at his office in the University of Colombo, 9 June 2010. He spoke about Dr Chinnatamby and her family planning activities with great admiration.
3. Within the scientific community, Chang was known as 'the sperm man' while Pincus was known as 'the egg man' (L. Marks, *Sexual Chemistry; A History of the Contraceptive Pill*, New Haven and London, Yale University Press, 2001, p. 90).
4. P. Vaughan, *The Pill on Trial*, London, Weidenfeld and Nicolson, 1970, pp. 31–44; and Marks, *Sexual Chemistry*, p. 107.
5. Chinnatamby, 'Perspective in Safe Motherhood', p. 7.

6. Ibid., p. 6.
7. J. Reed, *The Birth Control Movement and American Society: From Private Vice to Public Virtue*, New Jersey, Princeton University Press, 1984, p. 359.
8. A. Tone, *Devices and Desires: A History of Contraceptives in America*, New York, Hill and Wang, 2001, p. 204.
9. Marks, *Sexual Chemistry*, p. 94.
10. Vaughan, *The Pill on Trial*, pp. 31–44; and Marks, *Sexual Chemistry*, p. 107.
11. Marks, *Sexual Chemistry*, p. 97.
12. Ibid.
13. Ibid.
14. Ibid.
15. Ibid., p. 48.
16. Letter from Dr Sanyal to Dr Clarence Gamble, 29 April 1955, Countway Medical Library (CML) of Harvard University, Gamble Papers, Box 81, Folder 1286; and Letter from Dr Gamble to Mr Sherer, 30 June 1960, CML of Harvard University, Gamble Papers, Box 85, Folder 1352.
17. For this purpose, he placed paid workers at different geographies to work as family planning propaganda officers. One such energetic officer was Margaret F. Roots, who worked in Sri Lanka in the mid-1950s. Her reports to Gamble kept him informed of the internal politics and the family planning programme of the country.
18. Letter from Dr Clarence Gamble to Dr John Rock, 11 April 1955, CML of Harvard University, Gamble Papers, Box 195, Folder 3084.
19. Letter from Dr Clarence Gamble to Dr John Rock, 31 March 1955, CML of Harvard University, Gamble Papers, Box 195, Folder 3084.
20. Letter from Pincus to Lady Rama Rau, 3 January 1956, The Library of Congress (LOC), Washington DC, Manuscript Division, Gregory Pincus Papers, Box 23.
21. I did not find her reply in any of the following libraries: Countway Medical Library, Harvard Medical School in Boston, Library of Congress in Washington DC, Rockefeller Archive and Population Council in New York.
22. Letter from Pincus to Dr John Wyon, 20 January 1956, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 20.
23. Letter from Wyon to Pincus, 27 January 1956, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 20.
24. Letter from Gamble to Pincus, 2 October 1957, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 25.
25. Letter from Gamble to Pincus, 19 May 1958, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

26. I am grateful to my friend and colleague Rebecca Williams for sharing this information, gathered during her Ph.D. research in India in 2010.
27. Chinnatamby, 'Perspective in Safe Motherhood', p. 7; and Huston, *The Right to Choose*, p. 48.
28. Chinnatamby, 'Perspective in Safe Motherhood', p. 7.
29. *12th Annual Report of the Family Planning Association 1964–65*, Colombo, FPA, 1965, p. 12.
30. Ibid.
31. Chinnatamby, 'Perspective in Safe Motherhood', p. 9.
32. Ibid., p. 7.
33. Letter from J. William Crosson (assistant medical director of G.D. Searle & Co.) to Pincus, 13 June 1961, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 47.
34. Chinnatamby, 'Perspective in Safe Motherhood', p. 9.
35. Ibid., p. 8.
36. Ibid.
37. Siva Chinnatamby, 'Research', *17th Annual Report of the Family Planning Association 1969–70*, Colombo, FPA, 1971, p. 18; and Chinnatamby, 'Role of Research in the Family Planning Movement in Ceylon', in *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, p. 46. According to Chinnatamby, the other pills that were tested in Sri Lanka were 'Conovid E'; varying doses of Ethynodia Diacetate: 3mg, 2mg, 1mg; Ovulen, Lyndiol: 5mg, 2.5mg; Volidan with varying doses of megestrol with and without oestrogen; Volidan sequential 28; and Feminor, Ovral and Eugynon. *Fifteen Years of Family Planning in Ceylon 1953–1968*, p. 46.
38. Interview with the successor of Chinnatamby (former medical director) at the FPA, 16 February 2010, at her residence in Colombo.
39. The Vellala caste members in the Tamil community are primarily cultivators, as are the Goyigama caste members in the Sinhala community. Vellala is a dominant Tamil caste constituting well over 50 per cent of the Tamil population. Today, the Vellala community still comprises a large portion of the Tamil urban middle class. In the past, the Vellala formed the elite in the Jaffna kingdom and were the larger landlords; during the colonial period, they took advantage of new avenues for mobility and made up a large section of the educated, administrative middle class. See http://www.lankalibrary.com/cul/jaffna_castes.htm (accessed on 7 August 2024).
40. See <http://sundaytimes.lk/000109/plus10.html> (accessed on 7 August 2024). Gate Mudaliyar is a title given to locals who have served the British government with great loyalty. This class resembled the English country

squires. See http://en.wikipedia.org/wiki/Sri_Lankan_Mudaliyars (accessed on 7 August 2024).

41. P. Huston, *Motherhood by Choice: Pioneers in Women's Health and Family Planning*, New York, The Feminist Press, IPPF, 1992, p. 49. According to Huston, the death of Chinnatamby's sisters were responsible for her determination to 'contribute to the reduction of maternal and child mortality' in Sri Lanka.
42. See <http://sundaytimes.lk/000109/plus10.html> (accessed on 7 August 2024).
43. Chinnatamby, 'Perspective in Safe Motherhood', p. 2.
44. Ibid., p. 4.
45. Wilfred Perera, 'Dr. Siva Chinnatamby', *The Island*, 22 February 2001, p. 11.
46. Interview with the former dean of the Faculty of Medicine, University of Colombo (Chinnatamby's student in the 1970s), on 9 June 2010 and email communication on 2 October 2011.
47. Letter from Chinnatamby to Pincus, 5 February 1965, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.
48. Colombo 7 is a well sought-after residential neighbourhood inhabited by the upper-middle class who earned their wealth through colonial trade in the early 1900s.
49. Attested to by one of my aunts, who remembered Dr Chinnatamby as a close friend of her father's (a gynaecologist in the 1950s–60s) (5 December 2010).
50. Perera, 'Dr. Siva Chinnatamby'.
51. 'Triple Honour', *Ceylon Observer*, 15 April 1966, p. 6.
52. See <http://aofog.net/past.aspx> (accessed on 12 June 2024).
53. In 1940, it was renamed as De Soysa Maternity Home and in 1950, it was renamed again as De Soysa Hospital for Women.
54. T. Pancharatnam, '100 Years of Maternity Care', *The Sunday Times*, 25 November 1979, p. 8.
55. Ibid.
56. Charles De Soysa, who was from an upper-class Karava (second highest in the Sinhala caste hierarchy) family from Moratuwa, earned his wealth during the colonial period through his coffee plantations and trading activities; see <https://www.dmh.health.gov.lk/about-us/overview-history> (accessed on 12 June 2024). Many members of the Karava community engaged in social work, such as building educational institutions and hospitals, during this period by using the wealth they had amassed through colonial trade. See Jayawardena's *Nobodies to Somebodies*, 2000, for a comprehensive analysis of the Karava community in Sri Lanka.
57. Chinnatamby, 'Perspective in Safe Motherhood', pp. 4–5.
58. The FPA became an approved charitable institution only in 1965.

59. Marks, *Sexual Chemistry*, p. 138.
60. Letter from Ruth Crozier (Pincus' secretary) to Chinnatamby, 16 June 1961, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 47.
61. Chinnatamby, 'Perspective in Safe Motherhood', p. 9. See also Chinnatamby, 'Oral Contraceptives', in *11th Annual Report of the Family Planning Association of Ceylon 1963-64*, Colombo, FPA, 1964, p. 31.
62. Letter from Pincus to Chinnatamby, 26 January 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95; and Letter from Donna-Drew O'Connell to Chinnatamby, 6 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.
63. Letter from Pincus to Chinnatamby, 26 January 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.
64. Letter from Chinnatamby to Pincus, 3 February 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95. Letter from Chinnatamby to O'Connell, 22 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.
65. Letter from Pincus to Chinnatamby, 10 February 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.
66. Letter from Donna-Drew O'Connell to Chinnatamby, 6 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95; emphasis added.
67. de Silva (ed.), *A History of Family Planning*, p. 119.
68. 'Pill Safe', *The Ceylon Daily News*, 11 February 1970, p. 7.
69. 'The Pill: No Evidence of Danger, Says BMJ', *Ceylon Daily News*, 17 February 1970, p. 1.
70. 'Pill Safe', *The Ceylon Daily News*, p. 7.
71. M. P. Thero, 'Upath Palanaya Sinhala Vanda Kireemakda?' [Does Birth Control Suggest the Extinction of the Sinhala Race?], *Silumina*, 12 August 1969, p. 13.
72. Family planners spoke about the term *vanda beheth/pethi* in a rather disgusted tone during their interviews with me.
73. L. Jayawardena, 'Lingika Vidyawa ha Tharuna Parapura' (Sexual Science and the Young Generation), *Silumina*, 3 September 1969, p. 13.
74. Reporter, Sub Urban Council, Polgahawela, 'Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa: Eya Vahama Nathara Karanna' [Sterility Pills Make Sinhalese Nation a Minority: Stop this Immediately], *Dinamina*, 1 January 1970, p. 5. The term *vanda beheth* had been used at a sub-urban council meeting at Polgahawela, a town in the North Western Province.

75. Since I was born in 1975, during my early teens *Mithuri* had become a household name in Sri Lanka. So it was not surprising that I could not think of any other colloquial term for vanda beheth/pethi.
76. Little did they know that some militant African Americans had also perceived the tool as a 'genocidal weapon' and 'racist tool' in the 1970s (see E. S. Watkins, *On the Pill: A Social History of Oral Contraceptives 1950–1970*, Baltimore and London, The Johns Hopkins University Press, 1998, p. 56).
77. L. Jayawardena, 'Lingika Vidyawa ha Tharuna Parapura' [Sexual Science and the Younger Generation], *Silumina*, 3 September 1969, p. 13.
78. Reporter, Sub Urban Council, Polgahawela, 'Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa', p. 5.
79. All these five social categories are essentially Sinhalese Buddhists.
80. S. Bastian, S. Kottegoda, C. Orjuela and J. Uyangoda, *Power and Politics in the Shadow of Sri Lanka's Armed Conflict*, SIDA Studies No. 25, 2010, p. 40.
81. The anti-Tamil riots of 1958 are popularly known as *Shri* riots.
82. Thero, 'Upath Palanaya Sinhalayan Vanda Kireemakda?' p. 3.
83. Interview with the former medical director of the FPA, 16 February 2010, at her residence in Colombo.
84. Interview with former dean, Faculty of Medicine, University of Colombo, 9 June 2010, and email communication on 2 October 2011.
85. Scott, *Seeing Like a State*, p. 4. In his analysis of the failure of the human development schemes, Scott points out four elements that caused this failure: administrative ordering of nature and society, high-modernist ideology, authoritarian state and prostrate civil society.
86. Chinnatamby, 'Perspective in Safe Motherhood', p. 6.
87. Jayawardena, 'Lingika Vidyawa ha Tharuna Parapura', p. 13.
88. L. Jayawardena, 'Obata Daruwan Epada' [Don't You Want Children?], *Silumina*, 20 August 1969, p. 13.
89. There are three chapters (*nikayas*) in the Buddhist priestly order in Sri Lanka, based on caste. *Amarapura Nikaya* is the one where non-*govigama* priests take ordination.
90. Thero, 'Upath Palanaya Sinhalayan Vanda Kirimakda?' p. 13.
91. Siri Seevali Thero expressed his views in Jayawardena, 'Obata Daruwan Epada', p. 13. Vidyalkara Pirivena was originally a university for Buddhist monks, founded in 1875. Today, it is a full-fledged state university and its name was changed to University of Kelaniya.
92. Jayawardena, 'Lingika Vidyawa ha Tharuna Parapura', p. 13. (The English translation from Sinhalese is mine; emphasis added.)
93. Thero, 'Upath Palanaya Sinhalayan Vanda Kirimakda?' p. 13.

94. Silva, *Decolonisation, Development and Disease*, pp. 126–64.
95. M. D. Chaudhry, 'Population Policy in India', *Population and Environment* 11 (2), 1989, p. 104. For a detailed survey of Nirodh sales in India, see A. K. Jain, 'Marketing Research in the Nirodh Program', *Studies in Family Planning* 4 (7), 1973, pp. 184–90.
96. P. D. Harvey, 'The Impact of Condom Prices on Sales in Social Marketing Programs', *Studies in Family Planning* 25 (1), 1994, p. 52.
97. C. LaCheen, 'Population Control and The Pharmaceutical Industry', in *Adverse Effects: Women and the Pharmaceutical Industry*, ed. K. McDonnell, Ontario, Women's Educational Press, 1986, pp. 89–136; see p. 114.
98. J. Davies, 'Doctors and Community Based Pill Promotion in Sri Lanka', *IPPF Medical Bulletin*, London, IPPF, 9 (3), 1975, p. 1.
99. Ibid.
100. Ibid.
101. de Silva (ed.), *A History of Family Planning*, p. 57.
102. *Survey Report on Dealers and Potential Dealers of Contraceptives*, Colombo, FPA, 1981, p. 1.
103. Davies, 'Doctors and Community Based Pill Promotion', p. 2.
104. Newspaper advertisements and my interviews with retired school teachers, my doctor uncle, my mother, aunts and mother-in-law.
105. *Case Studies in Transfer of Technology: Pharmaceutical Policies in Sri Lanka*, Study by the UNCTAD Secretariat, United Nations, 1977, p. 2. K. McDonnell notes that the World Health Organization launched its Action Program on Essential Drugs only in 1977, which designated about 200 drugs that were known to be safe, cheap and of proven therapeutic value (see McDonnell [ed.], *Adverse Effects*).
106. *Case Studies in Transfer of Technology*, pp. 6–8.
107. Ibid., p. 8.
108. Ibid., p. 7. McDonnell points out that Bangladesh ordered off the market over 1,500 drugs that were considered hazardous or of questionable value in 1982 (see McDonnell [ed.], *Adverse Effects*).
109. *Case Studies in Transfer of Technology*, p. 8.
110. S. A. Wickramasinghe and S. Bibile, 'Pharmaceuticals Management in Ceylon', *British Medical Journal* 3, 1971, p. 758.
111. Davies, 'Doctors and Community Based Pill Promotion', p. 1.
112. LaCheen, 'Population Control and the Pharmaceutical Industry', p. 116.
113. *Family Planning Above Party Politics: Proceedings of a Seminar on Population and Development*, organised by the Ministry of Plan Implementation, 13 March 1980, Colombo, p. 12.

114. Davies, 'Doctors and Community Based Pill Promotion', p. 2.
115. Advertisement, 'because of love...', *Sunday Observer*, 19 August 1979, p. 6.
116. Interview with the retired secretary to the Ministry of Plan Implementation, 7 August 2011, at his office in Colombo.
117. Bordo, 'Feminism, Foucault and the Politics of the Body', p. 191.
118. Advertisement, 'Ganga Langa Kathawa' [Talk by the River], *Dinamina*, 13 August 1977, p. 8.
119. Bordo, 'Feminism, Foucault and the Politics of the Body', p. 191.
120. de Silva (ed.), *A History of Family Planning*, p. 33.
121. Ibid.
122. Ibid.
123. Davies, 'Doctors and Community Based Pill Promotion', p. 2.
124. *Annual Report of the Family Planning Association 1976*, p. 9.
125. Ibid.
126. Ibid., p. 18. One of the first 25 Ayurvedic physicians confided in me that 'the family planning training was a great opening at that time for the Ayurvedic physicians to get their lost status in society, especially among the middle class of the country'. Interview conducted on 6 April 2011 with Dr R. S. Jayawardhana, former dean of the Institute of Indigenous Medicine, University of Colombo.
127. de Silva (ed.), *A History of Family Planning*, p. 194.
128. *Annual Report of the Family Planning Association 1996/97*, Colombo, FPA, 1997, p. 33.
129. Watkins, *On the Pill*, p. 14.
130. McDonnell (ed.), *Adverse Effects*, p. 4.
131. Thoradeniya, 'Birth Control Pill Trials in Sri Lanka', p. 287.

4

The 1990s

Motherhood in a Decade of Turbulence

INTRODUCTION

Chronologically, Chapters 4 and 5 are, respectively, the continuation of Chapters 1 and 2, in which I placed a critical history of women's health in modern Sri Lanka within the global population and development discourses. In the preceding chapters, I argued that due to a controlled and planned women's health programme, Sri Lanka became a 'development model' for South Asia in the 1970s. As a result, the main focus of the women's health discourse became reproduction within a 'controlling and planning' ideology. By the 1980s, with the opening of the economy, Sri Lanka initiated dynamic development programmes, which were aimed at a careful population planning. As mentioned in Chapter 1, Sri Lanka came under strain in the 1990s due to economic and political turmoil.¹ The state re-defined and mobilised women and their bodies in particular ways, in response to this turmoil. This chapter investigates how the state framings of bodies of docile girls, responsible mothers and brave mothers in the 1990s affected the discourse on women's health in Sri Lanka.

The first section discusses the way the state has framed FTZ workers as docile and disciplined young women. The second section discusses responsible mothers in the Gulf, shouldering the economic hardships of the family. The third section discusses the role of brave mothers protecting the nation-state in times of governmental disorder. Migrant domestic labour and female-headed households created new ideas of motherhood in Sri Lanka. In the context of the militarised ethnic conflict, each faction deployed the concept of 'motherhood' in different ways.

The state's framing of these tropes of motherhood was crucial in the 1990s because the ideology shift in women's health towards an emphasis on reproductive health and rights could not be realised. It is necessary to explain the forms of 'motherhood' that were at play in the 1990s' Sri Lanka, and what I mean by patriarchy, before I proceed to analyse the three figures of womanhood.

WOMEN IN THE PATRIARCHAL WELFARE STATE

The 'ideology of motherhood' only makes sense in 1990s' Sri Lanka within the broader social, cultural, economic and political landscapes dominated by patriarchal norms and values. Patriarchy is a concept used in feminist, Marxist and socialist literature to analyse the principles underlying women's oppression. In feminist writing, patriarchy refers to 'male domination and to the power relationships by which men dominate women.'² In Marxist literature, patriarchy refers to kinship systems in which men exchange women and the symbolic power held by fathers within these systems. Demographer Caldwell referred to the Middle East, North Africa and South Asia as the 'patriarchal belt' based on the relationship between fertility rates and the status of women.³

A number of Scandinavian studies have been done on the relationship between the welfare state and women/motherhood in the 1970s and 1980s, which I found useful to the analysis of patriarchy and motherhood in 1990s' Sri Lanka. Arnlaug Leira noted that a number of feminist scholars, such as W. Seccombe, D. Costa and S. James, and Z. Eisenstein, conceive of the welfare state as 'patriarchal' and inherently oppressive because it organises social reproduction in a manner that assigns childcare and upbringing to women.⁴ They see it as a perpetuation of men's dominance and women's subordination.⁵ In her analysis of women's status as citizens, clients and employees of the state, Harriet Hernes argues that the welfare state exercises some form of 'tutelage' towards women in its policies.⁶ Contesting this interpretation, B. Siim (1984) contended that the welfare state forms a partnership with women in social reproduction.⁷ Drawing on Eisenstein's and Siim's works, Leira argues that the welfare state acts both as a 'patriarch' and in 'partnership' with women and their social reproductive role.⁸ When looking at the Sri Lankan welfare state, the

product of colonialism, I feel it is particularly patriarchal when it comes to the provision of free education and health care.

What I mean by patriarchy is the autonomy, power and privilege that men enjoy over women in Sri Lankan society. This power is not limited to the family; it extends to the community, village, work place and all human relations. All Sri Lankan women are subjected to patriarchy in varying degrees, depending on class and caste. Similar to other settings of the world, middle-class women in Sri Lanka are the most affected by patriarchy as they attempt to uphold moral values in society. Sometimes they view patriarchy as a moral value itself. However, curiously, families in Sri Lanka are, at the same time, both patriarchal and ideologically and functionally mother-centred. The mother is venerated as '*Gedara Budun*' (Buddha at home) and the father as the head of the house/family.⁹ Although the authority to take decisions in the family lies with the father, it is widespread practice that the mother plays a significant role in the father's decision.

The welfare state's patriarchal attitude and responsibility as the provider of free education and health services has made the Sri Lankan state adopt a form of paternal tutelage towards women. This could be seen especially regarding women's issues, such as family planning, contraception and nation-building (which also seems to have become the responsibility of women) in the 1990s, which I will discuss later under the themes of docile girls in FTZs, responsible mothers in the Gulf and brave mothers of the nation. I think turbulent events in the 1990s heightened the intensity and significance of the patriarchal nature of the Sri Lankan nation-state.

This chapter has three objectives. The first is to explain the centrality of the notion of womanhood and motherhood to the economic, military and political struggles of 1990s' Sri Lanka. The second is to explain why 'motherhood' was central as a symbolic language of the state and why it was crucially invoked and deployed in these three turbulent arenas. Even though 'motherhood' was central to how the state deployed women's bodies in the 1990s, the same 'motherhood' displaced women's health as a state strategy. By providing a critical analysis of the varieties of discourse on the woman's body and how they were deployed, the third objective of this chapter is to place the discourse on women's health and women's bodies

in a unified discursive frame with the aim of writing a critical history of women's health in modern Sri Lanka.

THREE FIGURES OF THE IDEOLOGY OF WOMANHOOD AND MOTHERHOOD

As mentioned in Chapter 1, even though SAPs were introduced to Sri Lanka to further liberalise the economy, 'women's empowerment' did not follow as expected by the proponents of the neoliberal agenda. The state made use of women's nimble fingers, and their docile, disciplined bodies in FTZs. The state deployed the traditional gendered roles assigned to the woman's body to support the economic development of the country during the escalating ethnic conflict of the 1990s (which I will discuss when I examine motherhood during the militarisation of the ethnic conflict).

Figure One: Docile Girls of the FTZs

The first FTZ of Sri Lanka was established in Katunayake in 1978. Many claimed that Sri Lankan women brought up in a strict patriarchal family background fitted well with the requirements of the global garment industry. To ensure the smooth supply of garments and to meet the demands of the global market, a disciplined and docile work force with 'nimble fingers' was put to work.¹⁰ Women employed in FTZs are mostly between the ages of 18 years and 25 years, and single.¹¹ Even though these women made and continue to make a major economic contribution to the country while working under all forms of exploitative conditions, they are respected neither in their villages nor in the new factory environment.¹² The economic growth that the country acquired through the garment industry was facilitated by a liberalised market, and globalisation pushed these women into a very uncomfortable situation at the local level.

Mainstream Sri Lankan society perceives garment workers as a group of women with loose and daring character, who are degrading the traditional cultural values of society.¹³ They do not fit into the ideal image of the Sinhala Buddhist woman, mainly due to the freedom that they enjoy away from the patriarchal family set-up.¹⁴ The idea of unmarried

girls living alone in hostels or boarding houses away from the patriarchal family structure opened the space to disrespect them as immodest in this new city culture. They are accused of crossing the border from the domestic to the public.¹⁵

Juki is the brand name of the Japanese sewing machine imported to the garment factories of Sri Lanka. Since the Juki is a high-speed sewing machine, garment workers undergo an on-the-job training before they can use it. Thus, garment workers were stigmatised as 'Juki *kello*' (Juki girls), 'Juki *kæli*' (Juki pieces) or 'Juki *badu*' (Juki things). The terms *kæli* (pieces) and *badu* (things) carry connotations of the garment workers' loose morals, their easy and licentious nature, and that they can be used and thrown away like a commodity. The Katunayake FTZ was generally referred to as *sthri puraya* (the city of women), *prema kalape* (love zone) and *vesa kapalape* (whore zone), also implying garment workers' loose character.¹⁶ Caitrin Lynch reminds us of the gravity of the stigma attached to these workers by quoting marriage proposal adverts in Sinhalese newspapers, which disqualify garment workers by including the phrase 'no garment girls' or 'no Juki girls'.¹⁷ 'Respectable' parents did not want their sons to marry girls assumed to be licentious, even though they were the ones shouldering the economic burden of the country. The same 'respectable' parents, however, would rejoice if they found graduate brides for their sons.

In response to the problem of the FTZ 'Juki girls', President Premadasa introduced the 200 Garment Factory Programme in 1992, where factories were built in villages and not in cities.¹⁸ Lynch recounts that the 200 Garment Factory Programme and the conflict situation in the country were neatly summed up in general usage as *gani Juki, pirimi tuwakku* ('women work in garment factories, men work in the army').¹⁹ Since the 200 Garment Factory Programme did not require girls to migrate from their parental homes in search of employment, they did not have to leave the domestic sphere and so these garment factories were seen as 'good'; the girls working in these factories were good Juki girls unlike the FTZ workers of Katunayake. Quoting Premadasa on these factory openings, Lynch points out that

Premadasa argued in numerous forums—from the moment he introduced the programme [200 Garment Factory Programme] to investors—that the

programme would bring discipline to the nation's rural heartland, which recently had been the source of revolutionaries for a violent youth revolt by the JVP.²⁰

Clearly, the President's statement shows the government taking on the patriarchal responsibility of disciplining the youth who were engaged in a violent revolutionary struggle against the state from 1987 to 1991. Furthermore, taking a nationalist standpoint, Premadasa called his initiative 'economic development through cultural preservation', which meant that he intended the garment workers of these 200 factories to be 'good Juki girls', unlike the Katunayake FTZ girls.²¹ These statements clearly manifest Premadasa's paternal responsibility not only towards the youth of Sri Lanka, but also towards developing the economy of the country by guiding rural women to become economically and culturally productive. In support of this decision, in 2003, six Sinhalese songs were composed and sung by renowned singers Victor Rathnayake, Deepika Priyadarshani and Rukantha Gunathilake to inspire people to praise and give due recognition to the apparel industry work force.²² Challenging the derogative term 'Juki kaeli', these songs address FTZ girls with respect by using terms such as *kumariye* (princess), *nangi* (younger sister), *diyaniya* (daughter) and *rajina* (queen). By recognising the burden that they shoulder when they take up work at a garment factory, these songs appeal to people to not frown upon them. *Amma bandu pemmaadara sammaguna piripun ema sannaliya nanga desa nobalan vaparaesakin* ('Do not frown at the younger sister, her [she] who bears mothers' love within her').²³ The idea of them bearing the country's burden on their shoulder, being the strength and the income generator for Mother Lanka, are some of the most powerful images that these songs created. These manifestations further facilitated the state's paternal role.

As mentioned in the introductory chapter, both FTZ workers and migrant women occupied a distinct and privileged position within contemporary state policies and the social milieu of Sri Lanka.²⁴ Both are significant for my book because their corporeality challenges traditional women's role within patriarchal society. By engaging in migrant employment they crossed the traditional domestic boundary and entered the public sphere. But by working in exploitative environments, they get trapped between enjoying their emancipation on the one hand and serving

the patriarchal state for economic development on the other. I consider them a group of women marginal to the body politic of the state, but central to the national economy. Because of this centrality, the state was more attentive towards regulating their bodies rather than caring for their health.

Given the importance that the state places on reproduction within the women's health agenda of Sri Lanka, it is not surprising that it took an indifferent stand on the health of these two groups of women because they are non-procreative bodies. My in-depth interviews with these two groups show how the state failed to accommodate the ideological shift from controlled and planned women's health to a reproductive health and rights agenda because women's bodies continued to be framed within traditional contours. The state did not cater to the health needs of FTZ workers and migrant women because, on the one hand, they are non-procreative bodies and bear no impact on the fertility rate of the country (which had reached replacement-level fertility by 1994), and on the other hand, the state did not perceive women's health beyond reproduction. The state's reproduction-centred women's health perception failed to accommodate the changing economic and geographic milieu, which bears a direct impact on these women's lives, health and bodies.

In order to understand how these two groups of women see their bodies and health, I conducted in-depth interviews with them. Having interviewed 10 women from each category in order to get a snapshot of the situation, I selected five from each category to conduct unstructured in-depth interviews.

Emergency Contraceptive Pill and FTZ Workers

My in-depth interviews with FTZ workers brought the state's perception of women's bodies as mobilised for economic development (at the macro level) and women's perception and understanding of their own bodies (at the micro level) into conversation. My interviews support my claim that the state remains indifferent towards FTZ women's health since they are non-procreative bodies.

All FTZ interviewees agreed that the general perception of garment workers has improved over the years, but at the same time they were very conscious of the fact that they have a less privileged position in society

despite their economic contribution to the country. Responding to my question about her perception of the body, Sita (one of the FTZ workers) summed up succinctly what others tried to explain in different ways:

We are treated as objects by men, we feel that all the time by the passing comments, jokes and looks that men give us, and also when travelling in the bus. We all want to dress up nicely, use shampoo, face wash and cream, adorn ourselves with the latest fashion jewellery, and perfumes. That does not mean that we should be treated as some kind of an object. It is indeed a pity that no man in this area would want to have an unselfish, decent romantic love like in *Gehenu Lamai* [referring to a popular teledrama based on a Sinhala novel in the 1950s] towards a garment girl. Men only get friendly with us for carnal pleasure; there is nothing more to most of the affairs that spring up here. Do you think that we like or enjoy that kind of treatment? No, we would love to be loved by men for what we are just like 'other' girls, but that freedom is snatched away from us by society.²⁵

Her longing for respect reminded me of a point made by one of the former executive directors of the FPA (1975–2005) during my conversations with him about the family planning programme of Sri Lanka during his time. He said:

[t]he government had neglected the two most sexually active groups: garment workers and migrant women, within the family planning programme. I personally see this as the government taking advantage of these two groups of women in order to boost the economy of the country at the expense of their well-being and social respect. Actually, the government has pushed them into prostitution.²⁶

His criticism of the government's insensitivity towards the consequences that these two groups of women had to face due to their work environments and Sita's yearning for social respect highlight two issues at hand. First, these comments point out how women are exploited in the liberal market economy. Second, they point towards the troubled position of the state operating in the liberal market economy. On the one hand, the state exploits the labour of FTZ and migrant women to develop the country's economy. On the other hand, the state remains insensitive to the negative attitudes that develop at home towards these workers for not conforming to socially accepted norms and behaviour. This indifference towards women's social

respect and dignity is clearly reflected in the health care service that the government provides to these docile girls.

Due to the very restrictive laws on abortion in Sri Lanka, there is no full data available. However, the FHB states that 'in 2008, 700 abortions were performed every day for a total of 250,000 a year. Last year [2011], this was up to a thousand a day for a total of 300,000 a year.'²⁷ Another study inquiring into the occupational status of abortion seekers testifies that garment factory workers stand out as the most represented group, with its members requesting 33.5 per cent of all abortions.²⁸ Since abortion is still illegal in Sri Lanka, these procedures are performed in inappropriate medical settings hazardous to health. In 2008, 11.7 per cent of maternal deaths were reported as resulting from septic abortions.²⁹ According to Savitri Goonesekere, eminent lawyer and human rights activist, despite many attempts since 1995 to broaden the exceptions and permit abortion 'in the event of rape, incest or grave foetal defects,' a permissive law did not materialise due to pressure from religious groups.³⁰ Given that 33.5 per cent of abortions are performed by FTZ women (garment factory workers), I asked Rekha (FTZ worker) about the service they receive from public health midwives (PHMs) in the area. Her prompt answer was, 'We have midwives visiting pregnant women in the area.' Then I asked about other services such as family planning and WWC tests that PHMs are expected to provide. Her answer was:

Midwives *only* visit pregnant women and they do not work on weekends, so it is very difficult for us to get their services. Whatever the knowledge we have on reproductive health, family planning and contraception is due to NGO workshops conducted by *Dabindu* or the FPA. Apart from that of course we [making a gesture towards her work colleagues] share what we know.³¹

As I have mentioned in Chapter 2, traditionally women are only expected to be sexually active within marriage (although this perception is rapidly changing at present) and thus the government family planning programme caters only to married couples.³²

Despite the evidence of abortion rates, largely unmarried cohorts of women FTZ workers do not come under the purview of the government family planning programme. Even though the former executive director of the FPA accused the government family planning programme of being

insensitive towards FTZ workers, the FPA, an NGO, reached the FTZs with the introduction of the Postinor 2, the emergency contraceptive pill, only in 1997. Educational programmes on reproductive health were conducted for the first time by the FPA in FTZs under the emergency contraceptive pill project. As reported by the FPA, 'these programmes were also aimed at promoting the use of the Emergency Contraceptive Pill to prevent unwanted pregnancies'.³³ I see a troubled connection between the educational programmes on reproductive health and the Postinor 2 project. Why did the FPA not conduct such educational programmes for FTZ workers before the Postinor 2 project? What is the relationship between the Postinor 2 project and the FPA conducting reproductive health programmes for the FTZ workers?

As was succinctly stated in the FPA's *Annual Report of 1998–99*, the FPA was not concerned about the health of FTZ workers, only about whether their reproductive bodies were producing 'unwanted' pregnancies that would blemish the women's health success story of South Asia. Rejoicing in the increasing sales of Postinor 2, the medical director of the FPA said to the *Sunday Times* (Sri Lanka) in 2003, 'Five years ago we sold 500 packets [Postinor 2] a month. Today we are selling 26,000 packets a month.'³⁴ This statement shows that there is hardly any difference between the state's women's health agenda and the FPA's agenda; both institutions are focused on keeping fertility rates under control rather than having a broader outlook towards women's health. In other words, the women's health programme of Sri Lanka is focused on silencing the bodies of the FTZ workers rather than providing them with safe health care facilities.

When considering all these incidents and points (the former executive director's comment on the government's attitude towards women's health, the high abortion rate among FTZ workers, FTZ workers' difficulty in accessing public health services and the FPA reaching FTZ workers only through the emergency contraceptive pill project), I find that they all add up to one particularly intriguing aspect of the discourse on the woman's body in 1990s' Sri Lanka. That is, it was not women's health or welfare that the national women's health programme was concerned about; instead, they wanted to keep women's reproductive bodies muted by using traditional markers. The state demands a disciplined docile body (within the traditional framework) from women to contribute to the GDP of the

country, but disregards the direct impact of this economic transformation and the new work environment on their lives, health and bodies. In other words, the primary premise of the woman's body discourse did not change in accordance with the changing economic milieu (second phase of SAPs), and women continued to be seen as 'reproducers, nurturers, disseminators of tradition, culture, community and nation'.³⁵ Because of the state's reproductive-centred perception of women's health and bodies, the state failed in its remit to look after the well-being of FTZ workers and their disciplined, docile bodies despite its long-standing welfare policy on public health care.

The other category of women who have crossed the boundary from the private to the public sphere through the neoliberal economy is the female migrant workers, whom I have identified as the second figure of womanhood in my book. Their bodies are framed by the state as responsible mothers in the Gulf.

Figure Two: Responsible Mothers in the Gulf

Just as women's labour contributed to the export income through the garment industry, women's labour constituted the largest portion of Sri Lanka's foreign exchange. Beginning with the 1970s, many South and South-East Asian countries began sending large numbers of their citizens to work in Gulf countries on short-term contracts. In Sri Lanka, the majority of these were female domestic workers. In 2008, the annual outflow of workers from Sri Lanka was around 200,000. Of this, 66 per cent were female domestic workers.³⁶ From 1999 to 2004, Sri Lanka's female migrant workers had earned Rs 478 billion (GBP 2.6 billion).³⁷ Their earnings have counted as the second highest source of foreign exchange for the country for more than two decades.³⁸ Mainly women from rural areas and from among the urban poor are recruited as housemaids by the government and private recruitment agencies. Recruiting agencies claimed that taking up housemaids' work in the Gulf meant simply a transfer of labour from the traditional setting to a new location. Women were expected to perform the same roles, which included cooking, cleaning, nursing, and caring for children, the elderly and the sick.

Even though they stepped out of the traditional place designated for women, the state re-framed those taking part in this new venture as responsible mothers who shoulder the economic hardships of the family. In other words, the state mobilised migrant women's labour by justifying their move outside their homes, re-framing them as responsible mothers. However, scholars have questioned the capacity of these women to fulfil their social reproductive role through migration.³⁹

Unlike FTZ workers, a large proportion of female migrant workers are married women, often with children. Scholars such as Sepali Kottegoda have shown that their earning capacity and exposure in the Gulf challenges the patriarchal power structure of the household.⁴⁰ Migrant women become the breadwinners of the family, and their child care duties are taken over by the husband and extended family members. The state framed this challenge to the patriarchal family order in such a way as to appeal to the maternal qualities of labour, emphasising how women sacrifice the comforts of their home to provide a better future for their family by labouring in the Gulf.⁴¹ This is well-articulated by both Devi and Sumana (migrant workers). Devi, 34 years old, married, living in a rented room (not a house) with her 5-year-old daughter and unemployed husband, said:

[m]y only consolation is that my mother and husband looked after my daughter. You know, Miss [referring to me], nowadays you cannot keep the daughter in the father's care [implying cases of incest]. I'm glad that I can rely on my husband for that, even though he is unemployed, he is a good man. I think nowadays it is men who have to trust [*vishvasa karanna*] their [housemaid] wives, not the other way round.⁴²

Unlike the docile girls of the FTZs, migrant women projected a strong sense of autonomy in their personalities. Sumana, a migrant worker aged 42 years, told me that she still spans her 16-year-old son if he is caught doing any mischief.

I am the mother and I earn a lot to give him a good future. So I will not tolerate any misconduct from him. [By misconduct, she means not attending school and tuition classes and associating with bad company.] He is my only child and son, taken care of by my mother and sister. I send enough money for his expenses. So he only has to study well. You know Miss, I saved money and bought him

a computer recently, because all I ask from him is to have a good education. And I believe that is all what we can do for our children, don't you think?⁴³

Even though Sumana's husband was working as an informal labourer, she spoke very little about him. The rest of the conversation was all about how she fulfils her maternal obligations. Devi's husband is unemployed and he takes care of their daughter. In both these households, women became the breadwinners and, in a sense, the husbands had switched roles with the wives. When she said 'husbands have to trust their wives', Devi emphasised that by switching roles, new power relations have developed in the household. Women exert autonomy in their own ways within the household as they perform the role of the responsible mother towards their children. Through the state's framing of the shifting role as responsible motherhood and the way women are performing this role, a new balance is being brought about in the traditional patriarchal family.

When I inquired about migrant workers' knowledge on reproductive health, Sumana's immediate response was, 'Unlike those days when we first went to the Middle East, nowadays women are given a training [language, handling of domestic appliances and health] from the Foreign Employment Bureau.'⁴⁴ To my question on her experience with sexual harassment on the job, she said:

this job is not for the innocent and naïve kind, then you are sure to get exploited sexually or otherwise. Personally I have never experienced any sort of exploitative treatment, I have worked in three households during the past 12 years and all treated me very well and I was ever so faithful to them. I know a woman, a friend of mine who was sexually harassed by the master of the house and we [friends] got together and found her another house through our contacts. She is from Madevachchiya [remote village in North Central Province of Sri Lanka], not like us brought up in town.⁴⁵

According to Sumana, women should be strong to take up migrant work in the Gulf. When she speaks of strength, Sumana refers to women's ability to make their own decisions. When women start making decisions, it affects patriarchal family relations because traditionally, decisions in relation to household expenses, domestic affairs and children's education are taken by the male/father in the family, not by the female/mother. By being strong

women, migrant workers are able to work in the Gulf, retaining respect, but the same strength in their character will disturb the power relations within the family. The idea of being good and strong mothers to their families came up very frequently during my interviews with migrant women.

The maternal responsibility emphasised both by the state and the women themselves suggests that these women form a new category as mothers without sexual desire. Leaving their homes for work is accepted as long as they abide by their domestic duty towards uplifting the family. Mothers are considered a group of asexual people with child-rearing responsibilities; within that nurturing and caring framework, their sexual desires are often sidelined through the veneration of motherhood. Analysing the SAP development programmes in the late 1980s, Jayaweera points out that by promoting home economics and gender-appropriate jobs for women, development planners and administrators at the decision-making level inadvertently promoted the 'housewifisation' of women.⁴⁶ Migrant domestic labour is indeed seen as a gender-appropriate job for women. I see the concept of housewifisation played out not only through the job that they perform, but also through the way the state perceives their bodies. Due to the responsibilities in the household and social reproduction that women are bestowed with, the state cannot perceive their bodies beyond reproduction. Because of their asexual bodies, responsible motherhood and housewifisation, they do not pose a threat to the fertility rates of the country, which allows the state to turn a blind eye to their health beyond reproduction.

Apart from the indifference towards the health of FTZ workers and migrant women 'beyond reproduction' in the 1990s, the state was also preoccupied with the ethnic conflict and the JVP uprising. These issues demanded that the state re-frame women's bodies further within traditional contours for nationalistic purposes. The state did not have adequate time or space to smoothen the rough edges of the traditional discourse on women's bodies according to the changing economic milieu. This was because the conflict situation in the 1990s threatening the Sinhalese Buddhist nation demanded that the woman's body discourse remain within the traditional framework.

In the midst of the militarisation of conflict, the state bestowed upon mothers a national role: as the brave mothers of war heroes, encouraging

women to enlist their sons in the national cause. The opposition also mobilised the concept of motherhood to pressure the government about the brutal retribution visited on the population in the wake of the JVP uprising. Both these forms of motherhood are based on Sinhala nationalist sentiments. Parallel to concepts of Sinhala motherhood, the Liberation Tigers of Tamil Eelam (LTTE) cast mothers as warrior mothers of the Tamil Eelam.

Figure Three: Motherhood during the Militarisation of Conflict in the 1990s

President Jayawardene's second term was convulsed by two conflicts. The first began with the Tamil separatist group, the LTTE, in the north and east of Sri Lanka in 1983.⁴⁷ In 1987, another conflict began with the youth group, JVP, in the south of Sri Lanka.

The ethnic flare-up in 1983 was a great impediment to Sri Lanka's open economy. Foreign investment and assistance were abruptly stopped. Instead, investors moved to Bangladesh and Pakistan, with their economies opening up in 1987 and 1988, respectively.⁴⁸ Sri Lanka's growth rate declined to 3.7 per cent during the period of 1983–89.⁴⁹ Economists have seen this catastrophe in the mid-1980s as a 'missed opportunity' for the country to become the first developed nation in South Asia.⁵⁰ The shift in economic priorities due to the ethnic conflict was termed by one scholar as switching from 'welfare' to 'warfare'.⁵¹

Apart from the ethnic conflict, the second JVP uprising of 1987 also further deteriorated the economy and the stability of the government.⁵² Although the JVP had existed as a political party and engaged in periodic struggles with the government since 1971, it was not banned until 1983. This led to another protracted armed struggle with the government.

According to a renowned anthropologist, the political violence and terror in southern Sri Lanka between 1988 and 1991 was unprecedented in scale when compared to the scale of the ethnic conflict in the north of Sri Lanka.⁵³ It was popularly known as *bheeshana samaya* (reign of terror). The intensity of the period can be seen from the widespread use of terms such as *athurudahanwoowo* (the disappeared), *wadhakagaraya* (torture chamber) and *issuwa* (kidnapped), which entered the popular vocabulary.⁵⁴

Paying attention to the overall structure and vocabulary of violence, Sasanka Perera adopts Taussig's term, 'culture of terror', to describe the political situation in southern Sri Lanka during the early 1990s.⁵⁵

It was indeed a reign of terror as thousands had 'disappeared' as a result of the brutal violence of the JVP and the retribution meted out by the UNP government of President Premadasa. State paramilitary forces called Black Cats and *Kola Koti* (Green Tigers) worked towards eliminating the JVP.⁵⁶ Both the JVP and the state committed human rights violations. Renowned political scientists Uyangoda and Samaranayake point to a clear ideological shift between the 1971 and 1987 JVP uprisings: from a 'revolution through class struggle to liberation through patriotic struggle' (de Silva 1998).⁵⁷ The state countered this patriotic struggle by adopting the similarly patriotic strategy of valorising motherhood. In the beginning of the 1990s, Sri Lanka was almost in a state of anarchy. The state was losing the battle on both ends (the ethnic conflict in the north and east and the JVP uprising in the south). Finally, in late 1989, Premadasa crushed the JVP in a counterinsurgency war by killing nearly 40,000–50,000 youth who believed the JVP ideology.⁵⁸ After crushing the JVP uprising, Premadasa established 200 garment factories, taking a paternal responsibility towards the nation (as mentioned earlier), in each of the 200 Assistant Government Agent (AGA) divisions of the country with the aim of creating nearly 100,000 jobs.

All three parties involved in these conflicts, namely the state (UNP regime), the LTTE and the JVP, mobilised motherhood in various ways to achieve their political ends.⁵⁹ The Sinhalese Buddhist state and the LTTE mobilised mothers rhetorically as nurturers, guardians and brave warriors of the nation who served to produce brave sons to protect the motherland.⁶⁰ S. Maunaguru reminds us that the LTTE appealed to women to join the *Eelam* (homeland) struggle from 1984 as it would 'prove the revolutionary potentialities of Tamil women'.⁶¹ The women's front of the LTTE was formed with the enlisting of women cadre in 1986, who were named *Sutantira Paravaikkal* (birds of freedom).⁶² Since this chapter is about the way the state framed womanhood and motherhood, I will be specifically looking into the two types of Sinhalese Buddhist motherhood espoused by the state (UNP) and the SLFP in opposition. Prior to that, it will be useful to provide a brief background of state policies directed towards women.

STATE POLICIES ON WOMEN

Even though the FPA was established in 1953 and the FHB in 1968 with the aim of keeping the population under control, there was no specific policy directed towards women till the UN declared 1975–85 as the decade of women. Studying the state's interest in women's issues, Selvy Thiruchandran notes that there seemed no necessity for gender-specific legislation as women enjoyed an empowered position in the Buddhist tradition due to un-gendered state policies on adult suffrage (universal adult suffrage was granted in 1931) and education (provisions for free education were made for both girls and boys in 1948) in Ceylon.⁶³ These achievements were celebrated both by policymakers and academics to generate an image of Sri Lanka as a template for other countries in the region. However, the state did not consider discrimination in wage structure, property relations, divorce, abortion and rape laws as important areas to be reviewed and revised. In response to the pressure exerted by UN donor agencies, the Women's Bureau and the Ministry for Women's Affairs were established in the 1980s.

Despite setting up institutions and adopting an open economic policy in 1977, policies on women remained confined to the traditional contours espoused by Dharmapala during the nationalist struggles of colonial Ceylon. The state could not address gender-specific issues even in the 1990s (as mentioned earlier), as it was under attack from two sides by the LTTE and the JVP. De Mel notes that despite the publishing of the Women's Charter in 1993, women's groups had to keep issues of 'domestic violence, sexual harassment, equal opportunities, abortion, women's access to safe contraception and informed choice about contraceptive methods, women's reproductive health, the image of women in the media, etc.', on hold due to the socio-political crisis in the country.⁶⁴ In fact, motherhood became an extremely important trope in the nation-building project in 1990s' Sri Lanka. With the militarisation of conflict, the state expanded the scope of mothers' responsibility from the family towards the nation, especially through the *Seva Vanitha* Movement (SVM). The literal meaning of *Seva Vanitha* is a ladies' movement to serve (*seva* = service and *vanitha* = women in Sinhala). The SVM was founded in June 1983 by Mrs Elena Jayawardena, wife of the then President J. R. Jayawardena. As a rule, the President's wife

automatically becomes the head of the SVM. Though a self-proclaimed non-political national movement, it is funded by the President's Fund. Its membership comprises of the wives of all government officials, from the grassroots level all the way up to the ministries.⁶⁵

TROPES OF MOTHERHOOD

Motherhood became an important trope during the ethnic conflict in Sri Lanka, which lasted 26 years (1983–2009). During the 1980s and 1990s, three groups of mothers organised active protest campaigns against the injustice, terror and violence of the state.

The Northern Mothers' Front

The first initiative to mobilise mothers for a political cause came in 1983 in protest against the state's tyrannical act of repression. In the North, the state arrested several Tamil boys suspected of 'terrorist activities'. Some were killed while others were tortured. Thiruchandran notes that ordinary women became radically politicised and joined the Mothers' Front upon hearing of and seeing the killings and torture carried out by the state.⁶⁶ The Northern Mothers' Front organised a march in June 1984, demanding that the government agent of Jaffna release their sons.⁶⁷ Nearly 10,000 women participated in this march.⁶⁸ Again, on 24 August 1984, over 500 women staged a demonstration against the alleged detention of youth by state security forces.⁶⁹ Even though these protest marches were not very successful, Thiruchandran sees this act of political protest by women as a moment of failed patriarchy, from which the Mothers' Front emerged as a form of contingent politics.⁷⁰

However, due to the prevailing ethnic tension, the Northern Mothers' Front could not form links with the South to seek a peaceful solution to the ethnic conflict; thus, it voluntarily disbanded in 1986 without submitting its cause to the LTTE, who tried to use it for its own political ends.⁷¹

The Southern Mothers' Front

In her message to the media on International Women's Day in 1990, the President's wife and head of the SVM, Mrs Hema Premadasa, emphasised

the woman's contribution to the family as care-givers, nurturers and upholders of morality. She extolled the 'patriotic endeavors of Vihara Maha Devi which resulted in the liberation of foreign domination', as one of the highest achievements of women, which extended from the family to the nation.⁷² The President's address at the International Women's Day meeting in Kandy also reiterated these ideas. He stressed the role of women in providing health care and nutrition to the family by taking Vihara Maha Devi as an example. 'History records the great effort made by Vihara Maha Devi to bring up her two sons as healthy and strong youngsters. It is said that at the age of 14 Prince Gemunu was the equal of any warrior in the King's Army.'⁷³ Supporting these claims, Mrs Premadasa unveiled the statue of Vihara Maha Devi in Kelaniya soon after the International Women's Day celebrations on 18 March 1990.⁷⁴ From these actions, it is clear that the state moulded women's role according to the characteristics of the legendary Sinhalese heroine queen Vihara Maha Devi. De Alwis, in her insightful analysis of Sinhala nationalism, shows how, during the 1990s, the state deployed Queen Vihara Maha Devi's famed patriotism, bravery and intelligence to give credence to women's role as reproducers of the nation and motherland.⁷⁵ Quoting speeches of President Premadasa and other prominent ministers of the 1990s, she shows how the state used the example of Queen Vihara Maha Devi's patriotism (even though she adopted violent means, thereby departing from the feminine quality of peacefulness) to create an ideology of brave motherhood, claiming it has always been part of Sinhala 'history', 'culture' and 'tradition'.⁷⁶ The idea of women as protectors of the nation keeps Dharmapala's notions of women's social reproductive responsibilities and duties towards the nation alive.⁷⁷

Addressing this crisis situation, the Mothers and Daughters of Lanka (MDL), a civil society organisation, was formed in 1989, which comprised women from diverse ethnic communities and religious backgrounds. Their appeal to 'stop killing' was not directed at any one particular political group but to all three parties (the state, the JVP and the LTTE).⁷⁸

While the MDL did not have any affiliation to a political party, the Southern Mothers' Front was established under the auspices of the opposition (SLFP) in 1990. Two SLFP parliamentarians at the time, namely the late Mangala Samaraweera and former President of Sri Lanka, Mahinda Rajapakse, inaugurated the Mothers' Front in the southern town of Matara,

demanding that the government carry out its patriarchal duty towards the nation by looking for the 'disappeared sons' (*athurudahanwoowo*).⁷⁹ Dr Manorani Saravanamuttu, mother of Richard de Soyza, broadcaster and journalist killed by the JVP on 18 February 1990, became the president of the national committee of the Mothers' Front. Although Tamil by ethnicity, her urban upper-middle-class identity and marriage into a prominent Sinhala family disqualified her from representing Tamil nationalism. Her desire was 'not to be anti-government in anyway' but 'to act as peaceful watchdogs'.⁸⁰

However, by using the emergency law, then minister of state for defence, Ranjan Wijeratne, banned the political demonstrations of the Mothers' Front as they were creating indiscipline and chaos. 'We want democracy through good behaviour. This government will not tolerate indiscipline any longer.'⁸¹ The government criticised the Mothers' Front, blaming its members for not bringing up their sons properly, forcing the government to establish camps to rehabilitate them. This implies that the government felt compelled to take over the responsibility that was traditionally assigned to mothers. Ranjan Wijeratne explained: 'Mothers are not expected to stage demonstrations. Mothers should have looked after their children. They failed to do that. They did not know what their children were doing. They did not do that and now they are crying.'⁸² By 'looking after', he implied that mothers should be able to stop their sons from becoming revolutionaries. Since mothers failed to do so, the government had to take on the responsibility and rehabilitate the youth. In other words, the government assumed its full responsibility, exercising the paternal power of protecting its women and children.

The Mother's Front soon expanded its membership to 25,000. The group engaged in activities initiated by the SLFP, such as *pada yathra* (walks), weeping, cursing and breaking coconuts (*pol gaseema*). In Sri Lankan society, where funeral rites are performed over a period of seven days, there is a specific cultural and emotional value to the dead body. To the mothers, the 'absence of bodies' signified the failure of the patriarchal state to provide protection to their children. In support of the Mothers' Front, Mrs Bandaranaike, the leader of the opposition, in her address at the International Women's Day in 1990, accused the government of making mothers live in fear and agony.⁸³

As a counter action, Mrs Hema Premadasa, the first lady, used her position as the president of the SVM (1988–93) to create another ideology—the ‘Nurturing Mother of the Nation’. Espousing traditional women’s duty and role in society, she carried out activities such as providing lunch for the soldiers in the battlefield, which went further than the charitable projects her predecessor carried out.⁸⁴ In response to the opposition SLFP’s Mothers’ Front, the party in power (UNP) formed its own Mothers’ Front in 1992, answering with ‘counter-rhetoric, counter-rallies and counter-ritual’.⁸⁵

Even though the founding members of the Southern Mothers’ Fronts did not intend to have any political affiliations, it was not possible due to the political unrest in the country, as politicians in the opposition made use of it to meet their ends. Thus, two Mothers’ Fronts were mobilised and made to carry the two main political ideologies (SLFP and UNP) of the day. Like the Northern Mothers’ Front which was disbanded in 1986, the Southern Mothers’ Fronts also lost their vigour in 1993. Despite being used by political parties to achieve their political goals, their protest activities created a new public space for women where they could voice their issues. When considering the activities of the Mothers’ Fronts, it is apparent that they redefined women’s traditional limits and helped women cross the boundary between private and public. They also mobilised the notion of motherhood for unfeminine public demonstrations, albeit within a highly traditional framework. By saying so, I do not suggest that the boundary between private and public does not exist anymore in women’s social role in Sri Lanka; it has, however, become more permeable. One other important aspect of the two Southern Mothers’ Fronts was that since the SLFP and UNP were addressing Sinhalese Buddhist sentiments through these organisations, these groups did not represent any other ethnic or religious community in the country.

At the same time, the state was not only enhancing and valorising, but also patronising motherhood due to the increasing number of female-headed households created by the conflict situation in the country.⁸⁶ I believe that the veneration and admiration of motherhood (whether Sinhalese or Tamil) pushed Sri Lanka further away from the programme of the Cairo conference. This happened due to the disconnect between the ideology shift the ICPD proposed on women’s health (from family

planning to reproductive health and rights) and the way the Sri Lankan state re-defined and mobilised women's bodies for a traditional social reproductive role.

By illustrating this disconnect between the shift in the global agenda on women's health and the state's discourse on the woman's body (through notions of docile girls, responsible mothers and brave mothers of the nation) in the 1990s, this chapter sets up the discussion in Chapter 5, which tries to bring the discourse on women's health and the woman's body into a unified discursive frame.

NOTES

1. For an insightful analysis of violence in 1990s' Sri Lanka, especially with regard to women, see M. de Alwis (ed.), *Cat's Eye: A Feminist Gaze on Current Issues*, Colombo, Social Scientists' Association, 2000. This book elaborates issues around the drafting of the Domestic Violence Bill in Sri Lanka, the debates on sexual harassment and the widely published rape cases during the 1990s.
2. V. Beechey, 'On Patriarchy', *Feminist Review* 3, 1979, p. 66.
3. J. Caldwell, *Theory of Fertility Decline*, London and New York, Academic Press, 1982. Further, for a conceptual analysis of patriarchy, refer to C. Delphy, *The Main Enemy*, London, Women's Research and Resource Centre, 1977; R. McDonough and R. Harrison, 'Patriarchy and Relations of Production', in *Feminism and Materialism*, eds A. Kuhn and A. M. Wolpe, London, Routledge & Kegan Paul, 1978, pp. 11–41; H. Hartmann, 'The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union', in *Women and Revolution: A Discussion of The Unhappy Marriage of Marxism and Feminism*, ed. L. Sargent, Montreal, Black Rose Books Ltd, 1981, pp. 1–41; I. Young, 'Beyond the Unhappy Marriage: A Critique of the Dual Systems Theory', in *Women and Revolution*, ed. L. Sargent, Montreal, Black Rose Books, 1981, pp. 43–69; H. Holter (ed.), *Patriarchy in a Welfare Society*, Oslo/Bergen/Stavanger/Tromsø, Universitetsforlaget, 1984; M. Mies, *Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour*, London, Zed Books, 1986; H. M. Hernes, *Welfare State and Woman Power: Essays in State Feminism*, Oslo, Norwegian University Press, 1987; and D. Kandiyoti, 'Bargaining with Patriarchy', *Gender & Society* 2, 1988, pp. 274–90.
4. A. Leira, *Welfare States and Working Mothers: The Scandinavian Experience*, Cambridge, Cambridge University Press, 1992, p. 167. See also W. Secombe,

'The Housewife and Her Labour under Capitalism', *New Left Review*, 83, 1974, pp. 3–24; C. M. Dalla and S. James, *The Power of Women and the Subversion of the Community*, Bristol, Falling Wall Press, 1975; Z. Eisenstein, 'Developing a Theory of Capitalist Patriarchy and Socialist Feminism', in *Capitalist Patriarchy and Socialist Feminism*, ed. Z. Eisenstein, New York, Monthly Review Press, 1979, pp. 5–40.

5. Leira, *Welfare States and Working Mothers*.
6. H. M. Hernes, 'Women and the Welfare State: The Transition from Private to Public Dependence', in Holter (ed.), *Patriarchy in a Welfare Society*, p. 39.
7. Siim, quoted in Leira, *Welfare States and Working Mothers*, p. 168.
8. Ibid.
9. When I was eight years old in 1983, this was one of the questions in my environmental studies test paper in grade 2. Today, 30 years later, my daughter has to learn the same thing in school for her environmental studies. This is one of the articulations of Dharmapala's project of civilising the bourgeois middle class in colonial Sri Lanka.
10. Lynch, *Juki Girls, Good Girls*, p. 27.
11. S. Kottegoda, 'Bringing Home the Money: Migration and Poverty in Gender Politics in Sri Lanka', in *Women and Migration in Asia, Volume 2: Poverty, Gender and Migration*, eds Sadhna Arya and Anupama Roy, New Delhi/Thousand Oaks/London, Sage Publications, 2006, p. 51.
12. For the exploitative conditions under which the FTZ workers work and live, see S. Jayaweera, *The Hidden Face of Development: Women, Work and Equality in Sri Lanka*, Colombo, CENWOR, 1989.
13. For an insightful analysis of Katunayake FTZ workers, see Hewamanne, *Stitching Identities in a Free Trade Zone*; for the 200 Garment Factory Programme, see Lynch, *Juki Girls, Good Girls*.
14. I will discuss the historical background of the creation of the ideal Sinhalese Buddhist woman in Chapter 5.
15. Even though women also leave their parental homes to go and live in university hostels in pursuit of tertiary education, they are not regarded as loose and daring. Like the garment factory girls, female university students, too, enjoy a particular freedom by being away from the patriarchal family set-up. They are not considered loose mainly due to the high regard that Sri Lankan society places on education. The same act of leaving the parental home creates two different perceptions about these two groups of women, merely because of the difference in purpose. For an insightful analysis of the notion of sexuality among university students, see E. Ruwanpura, 'Sex or Sensibility: The Making of Chaste Women and Promiscuous Men

in a Sri Lankan University Setting', unpublished Ph.D. diss., University of Edinburgh, 2011.

16. Hewamanne, *Stitching Identities in a Free Trade Zone*, p. 12.
17. Lynch, *Juki Girls, Good Girls*, p. 10.
18. The aim was to establish a garment factory in each of the 200 Assistant Government Agent (AGA) divisions in the country and to create nearly 100,000 jobs.
19. Lynch, *Juki Girls, Good Girls*, p. 27.
20. Caitrin Lynch, 'Economic Liberalization, Nationalism and Women's Morality', in *Economy, Culture, and Civil War in Sri Lanka*, eds D. Winslow and M. Woost, Bloomington and Indianapolis, Indiana University Press, 2004, p. 169.
21. Lynch, *Juki Girls, Good Girls*, p. 6.
22. 'Musical Tribute to the Juki Girls', *Sunday Observer*, 26 October 2003. 'Numba Rajinakayeyi Sithuna' ('You Seem like a Queen') is the title of the CD. See <https://archives.sundayobserver.lk/2003/10/26/mag02.html> (accessed on 13 June 2024).
23. *Sayurin Eha* (song 'Beyond the Sea' on the 'Numba Rajinakayeyi Sithuna' CD). See <http://www.youtube.com/watch?v=btSE6GMgl-o> (accessed on 13 August 2024).
24. See the studies by Hewamanne, *Stitching Identities in a Free Trade Zone*, and Gamburd, *The Kitchen Spoon's Handle*.
25. Interview with Sita (FTZ worker) on 18 September 2010 at her boarding place in Katunayake.
26. Interview with the first executive director of the FPA (1975–2005) on 21 December 2009. Prior to 1975, the FPA was managed by a Board of Directors.
27. See <http://www.asianews.it/news-en/Against-abortion,-Sri-Lankan-bishops-set-day-for-unborn-children-26315.html> (accessed on 13 August 2024).
28. L. Senanayake, S. Wilathgamuwa and K. Jayasinghe, *Reducing the Burden of Unsafe Abortion in Sri Lanka: A Situation Analysis and Plan of Action*, Colombo, FPA, 2009, p. 13.
29. R. Kumar, 'Abortion in Sri Lanka: The Double Standard', *American Journal of Public Health*, 10 (3), 2013, pp. 400–04.
30. S. Goonesekere, 'Gender, Equality and the Empowerment of Women in Sri Lanka', in *ICPD—'15 Years On' Sri Lanka: A Review of Progress*, ed. B. Weerakoon, Colombo, FPA, 2009, p. 30.
31. Interview with Rekha (FTZ worker) on 25 September 2010 at her boarding place in Katunayake. *Dabindu* Collective Sri Lanka is a women's organisation

established in 1984 in Katunayake that provides legal aid and counselling for women workers. It considers health as one of their priorities.

32. Ruwanpura shows us otherwise in her unpublished Ph.D. thesis, 'Sex or Sensibility'. In Chapter 5, I will discuss in detail when a woman becomes legible to the government health sector.
33. *Annual Report of the Family Planning Association, 1998–99*, Colombo, FPA, 2000, p. 3.
34. P. K. Balachandran, 'Anti-abortion Law Spurs Abortions', *The Sunday Times* (e-edition), 9 November 2009.
35. M. de Alwis, 'The Changing Role of Women in Sri Lankan Society', *Social Research* 69 (3), 2002, p. 675.
36. Annual Statistical Report of Foreign Employment 2008, Battaramulla, Sri Lanka Bureau of Foreign Employment, 2009, p. i.
37. S. Thiruchandran, 'Intersection of Labour Power, Female Sexuality and Notions of Nation State: The Cumulative Oppressive Process. The Case of Sri Lankan Migrant Housemaids', *Nivedini—Journal of Gender Studies* 11, 2004, pp. 76–77.
38. Kottegoda, 'Bringing Home the Money', p. 49.
39. See *ibid.*, pp. 60–63, for an analysis of the issues faced by migrant workers, such as a change in the domestic power structure and family catastrophes like eloping children, incest, child abuse by extended family members and extramarital relationships of husbands.
40. See Kottegoda, *Negotiating Household Politics*.
41. My frequent visits to Sri Lanka during the Ph.D. research (2009–12) gave me the opportunity to chat with migrant women on the flight to and from the Middle East. It was apparent from these conversations that these women had internalised the sacrificing mother ideology to a great extent.
42. Interview with Devi (migrant worker), 1 April 2010, at her house in Rajagiriya.
43. Interview with Sumana (migrant worker), 10 December 2010, at my house in Kotte.
44. *Ibid.* See <http://www.slbfe.lk/language-training/> for the training provided by the Foreign Employment Bureau of Sri Lanka for the migrant women (accessed on 12 June 2024).
45. Interview with Sumana (migrant worker), 10 December 2010, at my place in Kotte.
46. Jayaweera, *The Hidden Face of Development*, p. 12.
47. Since the 1950s, the Sri Lankan state has been pursuing a set of policies discriminatory against Tamils. These policies exacerbated ethnic tensions in the country for decades. In 1983, these tensions escalated into a full-blown

ethnic war. For a critical analysis of the ethnic conflict that lasted 26 years (1983–2009), see A. J. Wilson, *The Break-Up of Sri Lanka: The Sinhalese–Tamil Conflict*, London, Orient Longman Limited, 1988; J. Spencer (ed.), *Sri Lanka: History and the Roots of Conflict*, London & New York, Routledge, 1990; K. de Silva, *Reaping the Whirlwind: Ethnic Conflict, Ethnic Politics in Sri Lanka*, New Delhi, Penguin, 1998; A. J. Wilson, *Sri Lankan Tamil Nationalism: Its Origins and Developments in the 19th and 20th Centuries*, London, Hurst, 2000; D. Winslow and M. D. Woost (eds), *Economy, Culture, and Civil War in Sri Lanka*, Bloomington, Indiana University Press, 2004; K. Sivathamby, *The Sri Lankan Ethnic Crisis—A Tamil Perspective*, Marga Monograph Series on Ethnic Reconciliation, No. 25, Colombo, Marga Institute, 2004, and ‘The Sri Lankan Tamil Question: Socio-Economic and Ideological Issues’, *Security Dialogue*, 18 (4), 1987, pp. 621–35; and J. Uyangoda, *Ethnic Conflict in Sri Lanka: Changing Dynamics*, Policy Studies 32, Washington, East-West, Centre, 2007.

48. Kelegama, *Development Under Stress*, p. 68.
49. *Ibid.*, p. 54.
50. *Ibid.*, p. 68.
51. *Ibid.*, p. 59.
52. Rohana Wijeweera was a medical student studying at Lumumba University in Moscow when he established the JVP in 1965. Wijeweera was a great supporter of the Chinese Communist Party in Lumumba University at that time. The JVP did not have faith in the traditional left parties of Sri Lanka since they had been set up by educated bourgeoisie who gained their wealth by servicing the imperial economy during the colonial period.
53. S. Perera, *Stories of Survivors: Socio-Political Contexts of Female Headed Households in Post-Terror Southern Sri Lanka* (Volume 1), Colombo, Women’s Education and Research Centre, 1999, p. 19.
54. *Ibid.*
55. *Ibid.* By merely distributing a leaflet, the JVP made schools, offices and hospitals shut down and brought the national transport system to a complete halt. All the schools in the country were closed for three months (from September to December 1989). A number of academics, politicians, Buddhist monks, student political leaders, medical doctors, journalists and television presenters were abducted and assassinated by the JVP during this period. These abductions and assassinations were carried out by the *Deshapremi Janatha Vyaparaya* (DJV—‘Patriotic People’s Movement’), the armed wing of the JVP.
56. N. de Mel, *Women and the Nation’s Narrative: Gender and Nationalism in*

Twentieth Century Sri Lanka, Lanham, Boulder, New York, Rowman & Littlefield Publishers, Inc., 2001, p. 242.

57. J. de Silva, 'Praxis, Language and Silences: The July 1987 Uprising of the JVP in Sri Lanka', in *Sri Lanka Collective Identities Revisited Vol. II*, ed. Michael Roberts, Colombo, Marga Institute, 1998, p. 164.
58. According to Alles (1990), on 12 November 1989, the government managed to arrest JVP leader Rohana Wijeweera, who was killed in the process, although the murderers' identity is disputed. For more details on the JVP uprising in Sri Lanka, see Alles, *The JVP*.
59. The JVP had a female wing in the organisation from the beginning in the late 1960s, but the women's front of the LTTE was formed only in 1986. When women were deployed in the struggle, the state army also reacted accordingly. The Sri Lanka Army Women's Corps was formed in 1979 with six cadets. Today, there are seven units. All three armed forces mobilised the rhetoric of motherhood to achieve their own political ends.
60. Vihara Maha Devi in Sinhala literature and Kannada in Tamil literature are such warrior women.
61. *Thalir*, Issue 21, 1984, p. 31, quoted in S. Maunaguru, 'Gendering Tamil Nationalism', p. 163.
62. Thiruchandran, *The Other Victims of War*, p. xv; and C. Brun, 'Birds of Freedom; Young People, the LTTE, and Representations of Gender, Nationalism and Governance in Northern Sri Lanka', *Critical Asian Studies* 40 (3), 2008, p. 408. According to Peter Schalk, the first Tamil female fighters were trained in India in 1982. See Peter Schalk, 'Women Fighters of the Liberation Tigers of Tamil Elam: The Martial Feminism of Atel Palacinkam', *South Asia Research* 14 (2), 1994, pp. 163–95.
63. S. Thiruchandran, *The Politics of Gender and Women's Agency in Post-Colonial Sri Lanka*, Colombo, Women's Education and Research Centre, 1997, p. 9.
64. de Mel, *Women and the Nation's Narrative*, p. 235.
65. See M. de Alwis, 'Gender, Politics and the "Respectable Lady"', in *Unmaking the Nation*, eds Jeganathan and Ismail, pp. 137–57.
66. Thiruchandran, *The Politics of Gender and Women's Agency*, p. 41.
67. *Ibid.*, p. 42.
68. *Ibid.*
69. 'Demo by Women in Jaffna', *Daily News*, 25 August 1984, p. 1.
70. Thiruchandran, *The Politics of Gender and Women's Agency*, p. 43.
71. Maunaguru, 'Gendering Tamil Nationalism', p. 168; and Thiruchandran, *The Politics of Gender and Women's Agency*, p. 44.

72. 'No Strong Society without Women,' *The Island* (International Women's Day Supplement), 8 March 1990.
73. 'Govt. Has Given Women Their Due Place in Many Respects—President,' *The Island*, 12 March 1990, pp. 1–2.
74. 'Vihara Maha Devi's Life—A Classic Example to All Women,' *The Island*, 19 March 1990, p. 3.
75. de Alwis, 'The Moral Mother Syndrome,' p. 69.
76. Ibid.
77. See de Mel, *Militarizing Sri Lanka*, for an insightful analysis of women's bodies in the militarised neo-liberal state of Sri Lanka.
78. See de Mel, *Women and the Nation's Narrative*, p. 238.
79. Ibid., p. 244. Samaraweera and Rajapakse were inspired by the Mothers' Front of Argentina's Plaza de Mayo to organise the Southern Mothers' Front in Sri Lanka.
80. 'Mothers' Front Pro-peace, Not Anti-govt,' *Daily News*, 20 February 1991, p. 10.
81. 'Political Meetings, Picketing, but No Demos—Ranjan,' *Daily News*, 15 February 1991, p. 1.
82. *Daily News*, 15 February 1991, quoted in M. de Alwis, 'Motherhood as a Space of Protest: Women's Political Participation in Contemporary Sri Lanka,' in *Appropriating Gender: Women's Activism and Politicized Religion in South Asia*, eds P. Jeffery and A. Basu, New York/London, Routledge, 1998, p. 188.
83. 'Mothers Now Live in Fear and Agony, Says Mrs. B,' *The Island*, 9 March 1990, p. 1.
84. de Mel, *Women and the Nation's Narrative*, p. 146.
85. de Alwis, 'Motherhood as a Space of Protest,' p. 188.
86. See Thiruchandran, *The Other Victims of War*, for an analysis of how the concept of breadwinner in the traditional patriarchal household changed with the war situation in Sri Lanka.

5

Reproductive Health and Rights in Sri Lanka

INTRODUCTION

Amidst the economic transformation and political turmoil of the last decade of the twentieth century, discussed in Chapter 4, the state launched two ambitious women's health policy initiatives. One of them was an island-wide WWC programme launched in 1996, and the other a Population and Reproductive Health policy (PRH) designed in 1998. Both these initiatives were adopted in response to the ICPD (or Cairo) held in Cairo in 1994. Cairo was widely hailed for its call to end the prevailing coercive, target-based approach to population control in favour of an approach that centred on reproductive health and rights.¹ This chapter discusses how the post-Cairo WWC programme and PRH policy emerged at the same moment as the state was framing women's bodies around motherhood. In particular, this chapter examines the ideological products of this conjunction. While the WWC programme and the PRH policy attempted to shift the narrow family planning focus on women's health to a reproductive health and rights agenda—which I call 'beyond reproduction'—the state was framing women's bodies within a discourse of social reproduction and motherhood in response to the turbulent events of the 1990s. This chapter examines how a women's health ideology 'beyond reproduction' worked alongside the state's ideology of 'motherhood' (essentially framed around social reproduction) in 1990s' Sri Lanka.

However, the WWC programme is puzzling. Although the ICPD proposed to introduce a reproductive health and rights approach to women's health, there is no mention of reproductive rights in the materials

published by the FHB of Sri Lanka on the WWC programme. The WWC policy solely emphasises reproductive health. Further, with reference to preventing disease by screening women's bodies against 'common non-communicable diseases such as hypertension and diabetes, breast malignancies and cervical cancers,' the material published by the FHB affirms that the WWC programme introduced a reproductive health approach to women's health, whilst saying nothing about reproductive rights.² The PRH policy presents a similarly puzzling disjuncture. As mentioned in Chapter 1, even though the Sri Lankan state had identified the need for a population policy at the beginning of the 1950s, the PRH policy document was not produced until almost half-a-century later (in 1998); Sri Lanka had already reached replacement-level fertility four years earlier (in 1994). The PRH policy was also silent on reproductive rights and targets; it aimed instead to 'achieve a stable population size at least by the middle of the 21st Century'.³

As policy initiatives, both the WWC programme and the PRH policy were problematic because neither mentioned reproductive rights. Nevertheless, they jointly represented a move to embrace a new era in global women's health policy characterised by reproductive health and reproductive rights. In principle, these policies might have moved 'beyond reproduction' (by freeing women's bodies from reproducing the nation and by treating them as human bodies possessing individual rights as citizens of Sri Lanka). However, these initiatives came at a time when the state was casting women as responsible and brave mothers within the nation-building project of the turbulent 1990s. As a result, this new veneration of motherhood precluded the women's health programme from adopting a comprehensive women's health approach. Thus, it raises the question: Is it possible to promote reproductive rights in the absence of human rights?

The aim of this chapter is to comprehend Sri Lanka's WWC programme and PRH policy alongside both global health policy initiatives and Sri Lankan political imperatives. As a result, this chapter is structured around the multiple disconnections that the WWC programme and PRH policy produced, at global, national and corporeal levels. I used material collected from interviews conducted with the architects, implementers and users of these programmes to show these multiple disconnections. I contend that these disconnections stem from an understanding of the discourses on

women's health and the woman's body that sees them as separate entities existing in different territories and epistemes, disregarding the mutual inclusiveness of the two.

Since both these policy initiatives are consequences of the ICPD in Cairo, it is necessary that I begin by providing a brief history of the international conferences held to discuss population and development issues. After this, I will discuss the new shift in women's health—from family planning to reproductive health and rights—proposed at the ICPD, and its effect on the women's health programme in Sri Lanka. I will then discuss the WWC and the PRH policies in turn. The 'Cairo consensus' finally drafted a global strategy which had begun two decades earlier (in 1974). This consensus claimed that population control was a necessary precondition for development.⁴ Even though the Cairo consensus was produced after much deliberation and lobbying by women's groups and civil society organisations, there has been a plethora of critical work written about Cairo. However, a majority of these works agree that Cairo was a watershed moment for contemporary discourses on population, development and women's health.⁵

ICPD CAIRO: FROM FAMILY PLANNING TO REPRODUCTIVE HEALTH AND RIGHTS

The first International Population Conference of an official governmental nature was held in Bucharest in 1974. It was attended by representatives of 135 countries.⁶ Representatives of India came up with an innovative slogan, 'development is the best contraceptive', and requested First World nations to help the Third World in achieving their development goals.⁷ No overall global targets for population growth were set. However, by the late 1970s the two most populous countries in the world, India and China, had implemented austere population control measures, which some claimed were the direct results of such a 'developmentalist' approach.⁸ India introduced 'sterilisation camps' and China introduced the 'One Child Policy' in 1978.⁹

The second International Population Conference was held in Mexico 10 years later. The secretary general of the 1984 conference and executive director of the UNFPA, Rafael Salas, made an explicit commitment to set

a specific target in Mexico. He declared: 'Our goal is the stabilisation of global population within the shortest period possible before the end of the next century.'¹⁰ Even though the 1974 and 1984 conferences did not produce a concrete plan of action, they contributed in numerous ways to the shaping of a global discourse on population and development.

The third decennial conference was held in Cairo in 1994, where 179 countries pledged to incorporate reproductive health and rights measures in their women's health programmes. The Cairo Programme of Action (PoA) urged a move away from coercive measures of population control towards a new emancipated reproductive health and rights agenda.¹¹ Unlike the previous decennial conferences, the ethos of Cairo marked a definite shift in the global agenda on women's health—from a Malthusian focus on population control to a broader concern with reproductive health and rights.¹² Scholars have noted that the language of Cairo clearly 'downplays' and 'undermines' the significance of the term 'population', effecting a rhetorical shift from 'population control' to 'women's empowerment'.¹³ This paved the way for a wide range of policy discourses and practices.¹⁴

Rosalind Petchesky suggests that the significance of Cairo's PoA was threefold. In addition to enacting a move away from narrow demographic targets to a reproductive health approach, Cairo also integrated 'the principles of gender equality, equity and women's empowerment into population and development strategies' and explicitly recognised 'reproductive rights, very broadly defined and linked to primary health care, as fundamental human rights'.¹⁵ Betsy Hartmann points out that the other significant outcome of Cairo was the emergence of a liberalising market agenda to govern women's health and bodies.¹⁶ Further, she argues that the ICPD had 'sold' the idea of encouraging small families through motivational efforts by making coercion implicit and repackaging it as a 'consumer choice'.¹⁷

In the context of India, Rachel Simon-Kumar says the ICPD influenced the shift 'from an incentive-based to a target-free approach, from population control to reproductive agency' and 'from numerical quotas to informed choices' as a way of explaining how the post-Cairo reproductive and child health policy of India became a 'missed chance' rather than a feminist policy.¹⁸

Following Hartmann and Simon-Kumar, I investigate how Sri Lanka's WWC and PRH policies 'translated' Cairo's 'achievements' during the 1990s. The leader of the Sri Lankan delegation to the ICPD Cairo, Deshamanya Bradman Weerakoon, described the Cairo consensus as a set of guidelines to plan and implement population programmes

from primarily, societal goals to individual rights; from family planning to reproductive health and reproductive rights; from population reduction to women's health and the welfare of women, men and children; and from vertical health service delivery to integrated services.¹⁹

In line with this paradigm shift, the WWC programme was introduced as a reproductive health initiative to address women's health 'beyond reproduction'.²⁰ Further, to the credit of the women's health 'success story', Sri Lanka was the first in South Asia to launch a government-run WWC programme.²¹ The government's stated aim in launching this programme was to introduce the concept of reproductive health in order to enhance women's health in Sri Lanka. This was written in Sinhala as '*Suvanari sayana kanthavange saukya thathvaya nagasituveema aramunu karagena prajanana saukya sankalpaya yatathe kriyathmaka karanalada nawa sayanika sevavaki*' in the handbook on WWCs.²² Despite the political turmoil of the 1990s, Sri Lanka launched an island-wide WWC programme in 1996.

WELL WOMAN CLINICS

Although the WWCs were new to Sri Lanka in 1996, the concept had been in existence since the 1940s.²³ Such clinics were initially developed as an extension of preventive medical care in the US. Its promoters claimed that these clinics originally afforded healthy women, 'who claimed to be free of complaints', an opportunity to undergo a 'routine medical check-up' in the US and Canada.²⁴ WWCs were also introduced in the UK between the late 1960s and early 1970s.²⁵ These WWCs were

set up to screen women for cervical cancer and breast abnormalities. They then developed into 'Well-Woman' clinics with the addition of other investigations (urinalysis, blood pressure estimation, haemoglobin estimation, pelvic

examination, and a general check-up), and by allowing women to discuss any problems they might have with the clinic doctor.²⁶

The first National Conference on WWCs was held in Manchester in 1981. It was convened by the National Association of Community Health Councils in order to bring together the various groups providing such clinical services.²⁷

WELL WOMAN CLINIC PROGRAMME OF SRI LANKA—1996

The WWC programme was launched in Sri Lanka in 1996 as a consequence of the ICPD. It came under the auspices of the FHB, the central organisation of the Ministry of Health (MoH) responsible for planning, coordinating, monitoring and evaluating the maternal and child health (MCH) and family planning programme in Sri Lanka.²⁸ The stated objective of the WWC programme was

Avurudu 35ta vædi kanthavan muhunapæhæki pradhana rogi thathvayan kihipayak handunagæneemen ovunge saukya thathvaya vædi diyunu kireema mema vadasatahane aramunai [to improve women's health by early detection of common, non-communicable diseases such as hypertension, breast cancer, Diabetes Mellitus and cervical cancer of women who are past their reproductive age of 35 years].²⁹

As in the West where they originated, WWCs were set up in Sri Lanka within the sphere of preventive medicine as 'screening centres' and not as centres for treatment.³⁰

Since the inception of the programme, the FHB has issued three circulars and published one handbook providing guidance on how to implement the WWC programme.³¹ The WWCs function at the base of the well-structured public health system in Sri Lanka (i.e., health unit). They provide free medical access to women from every strata of society. The Medical Officer of Health (MOH) is responsible for preventive and promotional health care in a defined area known as a health unit. Currently, there are 354 health units in Sri Lanka headed by a Medical Officer/Maternal and Child Health (MO/MCH) carrying out the Reproductive,

Maternal, Newborn, Child Adolescent and Youth Health programme (RMNCAYH).³² The first WWC was set up in June 1996 in the Kalutara district in the Western Province of Sri Lanka.³³ By the end of 2019, 1,000 WWCs were functioning in the country, based mostly at pre-existing health centres run by Medical Officers of Health.³⁴ According to the strategic plan for WW programme 2019–23, all provincial/district health managers are expected to strengthen the programme by establishing at least one functioning WWC for every 15,000 population.³⁵

Even though the leader of the Sri Lankan delegation to the ICPD in Cairo identified reproductive rights as a concept that Sri Lanka should introduce in order to uplift women's health in the country, surprisingly, I did not come across the term 'reproductive rights' in any of the official documents relating to the WWC programme published by the FHB.

DID REPRODUCTIVE RIGHTS MISS THE FLIGHT FROM CAIRO?

Is the absence of reproductive rights in government rhetoric a 'mistake or an oversight' on the part of the government, or is it a deliberate policy decision made at the level of implementation? I see this absence of reproductive rights both as an 'official oversight' and 'official impasse' of 1990s' Sri Lanka.

The term 'reproductive rights' was not coined at the ICPD in Cairo; rather, it emerged during the 1980s as a consequence of the second wave of feminism in the 1970s, largely generated by the women's movements in North America, Europe, Australia and Latin America.³⁶ Petchesky points out that women's rights' movements in both the Global North and the Global South developed and expanded the concept of reproductive health and sexual rights through a 'cross fertilisation of ideas—across many countries and continents' during the 1990s.³⁷ They were brought onto international platforms at the World Conference on Human Rights in Vienna in 1993, the ICPD in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995.³⁸

Even though the annual reports of the FPA have explicitly articulated the concept of reproductive rights in the gender equity and women's empowerment programme that began in 1997, it was carefully omitted

from the official rhetoric of women's health in Sri Lanka.³⁹ I would be a careless reader of official documents if I were to brush this off as a 'mistake' made by the FHB. Rather, I see this primarily as an 'official oversight' due to the over-emphasis placed on demographic indicators. Second, I see this omission as an 'official impasse', wherein the state was incapable of producing a reproductive rights discourse at a time when human rights were being undermined.

Reproductive Rights as an 'Official Oversight'

In the context of Sri Lanka's demographic history, the policy shift from family planning to reproductive health sounds—ostensibly—convincing, considering that Sri Lanka had achieved replacement-level fertility in 1994. By 1996, the state could claim that population was no longer a 'problem' for development.⁴⁰ Deshamanya Bradman Weerakoon, leader of the Sri Lankan delegation to Cairo, also attested in his speech at the ICPD that, 'Sri Lanka has reached the final stage of its demographic transition. The annual rate of population growth has come down to 1.2 per cent, the total fertility rate is 2.2 and the life expectancy for women is almost 75 years.'⁴¹ Therefore, after the Cairo conference, the establishment of the WWC programme as a reproductive health initiative appeared—according to demographic and developmental thinking—the logical and best step forward.

However, when I asked officials at the FHB why Sri Lanka decided to launch a WWC programme at this particular moment, I received very vague answers, such as, 'After the ICPD [the] Minister of Health decided to launch it and [the] UNFPA provided technical and financial assistance, so here we are with WWCs.'⁴² Nevertheless, it provides some insight into the day-to-day workings and decision-making processes of the FHB. It also depicts the usual lack of resources (monetary and expertise/technology) story of the Third World.⁴³ This was a decision made from above (first at Cairo and then by the minister of health); hence, the officials were compelled to implement it without further questioning or deliberation. Additionally, the FHB doctors involved with the launching of the WWC programme confided in me that it was indeed a 'mistake' to launch a national programme without conducting a feasibility study. During my discussions with the WWC programme designers and implementers, it was

evident that the inception of the WWC programme was mainly a political decision taken by the then Minister of Health and Nutrition, A. H. M. Fowzie. For policymakers and implementers, the 'mistake' was a procedural one: failing to conduct a feasibility study prior to implementing an island-wide WWC programme. But, what is at stake in this mistake? I find all these procedural mechanisms rather meaningless when policymakers turn a blind eye to the larger picture that has serious implications for women's health and bodies. From my interviews with the policymakers of the WWC programme, it was clear that they did not recognise that the conceptual shift proposed at the ICPD should have been reflected in the programme. They were simply interested in implementing orders from above, and in procedural mechanisms of programme implementation. In short, the FHB of Sri Lanka launched the WWC programme in 1996 without engaging with the conceptual/ideological shift that the ICPD was supposed to have enacted because of the way in which funds and technical support came from the UNFPA: in a neat technocratic package.

When I posed the same questions [Why did Sri Lanka decide to launch a WWC programme in 1996? Do you think Sri Lanka was ready to launch such a programme then?] to the present WWC programme director of the UNFPA, she evaded them by saying that, 'it is a chicken and egg situation.' According to her, I was asking the wrong set of questions.⁴⁴ She explained that:

The important thing about the WWC programme is how it performs today. Not about questioning its timing. When introducing a new programme, it is very difficult to say how it will be received by the public. So whether we should wait until the time is ripe to launch the WWC programme or whether we should launch the programme and make it happen is a very intricate question.⁴⁵

According to her, the most important thing about the WWC programme is its performance: for Sri Lanka to be the first in South Asia to launch an island-wide WWC programme through the government health care sector.⁴⁶ By 'performance', she meant encouraging more women to attend WWCs to be examined in order to detect common, non-communicable diseases. She then spoke of the WWC programme in laudatory terms, emphasising its operation even within the war zone during the ethnic conflict. She emphasised that

The WWC programme is a government programme. The UNFPA is only providing technical support in terms of training the pathologists and cytologists and also the screening procedures and equipment. The monetary contribution is insignificant.⁴⁷

During the interview, she clearly placed the donor (UNFPA) and recipient (Government of Sri Lanka; in this case, the FHB) within an international discourse on women's health by defining each party's role and the limited support provided by the UNFPA.

From my conversations with officials at the FHB and the UNFPA, it is clear that both these institutions have clearly demarcated their respective positions and defined their implementation procedures within the WWC programme, but have not made any effort to understand the paradigm shift that the ICPD calls for within the WWC programme or considered how it would affect women at the grassroots level. I believe that the FHB and UNFPA officials were too eager to make this shift in order to be the first in South Asia to do so, thus upholding Sri Lanka's long-standing record of possessing the best women's health indicators in the region. In their eagerness, officials 'overlooked' the concept of reproductive rights, making the WWC programme a half-realised dream of a post-ICPD women's health programme for Sri Lanka. After achieving replacement-level fertility, the next demographic step was to adopt a comprehensive women's health approach by shifting from family planning to reproductive health. Conferring reproductive rights to women was not seen as a demographic necessity.

Reproductive Rights as an 'Official Impasse'

Analysing the Cairo PoA, Petchesky points out that reproductive rights (in a very broad sense) are defined by and linked to fundamental human rights.⁴⁸ In the absence of Sri Lankans enjoying fundamental human rights in the 1990s, it is very unlikely that women's reproductive rights (that is, the right to make decisions about one's reproductive body, free from direct or indirect coercion) would be included in an official policy or everyday bureaucratic practice. Discussing women's activities in 1990s' Sri Lanka, a feminist scholar says that 'women's groups had to keep the issues of domestic violence, sexual harassment, equal opportunities,

abortion, women's access to safe contraception and informed choice about contraceptive methods, women's reproductive health, the image of women in the media etc. on hold' due to the socio-political crisis within the country in the 1990s.⁴⁹ Supporting de Mel's argument, an eminent lawyer points out that a bill to broaden the exceptions and permit abortion in the event of rape, incest or grave foetal defects was withdrawn under pressure from religious groups in 1995, even before it was tabled in Parliament.⁵⁰ This confirms that reproductive rights were positioned far away from the sealed doors of human rights in 1990s Sri Lanka.

Furthermore, the 'official impasse' to confer reproductive rights to women could be clearly seen in the FHB officials' attitude towards women. During my conversations with the policymakers of the WWC programme at the FHB, the idea of denying rights when offering a free service came up frequently. This is aptly expressed in the common Sinhala idiom *nikam dena assayage dath balanne næne*, which means 'do not look a gift horse in the mouth'. When reproductive health is provided as a free service, government officials did not (and do not) see reproductive rights as women's rights which the government should confer on them. The long history of welfarism in Sri Lanka made women beneficiaries of the public health system, which in turn made them indebted to the state for what they were receiving free of charge. Consequently, they grew ignorant of their rights as citizens. In her analysis of the importance of social welfare policies in the lives of Scandinavian women, Helga Maria Hernes deals with a very intriguing question (that also applies to the welfare health policy of Sri Lanka), which is

whether women's status as clients and their political profile as recipients has prolonged and institutionalised their powerlessness, or whether the minimum livelihood that the welfare state has guaranteed them has given them the opportunity and the resources to wage their war of independence.⁵¹

From my interviews, it is clear that their prolonged 'beneficiary' status caused women to 'institutionalise their powerlessness'. As shown in Chapter 3, free distribution of the Pill by midwives is a clear indication of women's powerlessness within the public health system. This situation deteriorated further in the 1990s, once women were considered national

objects, thanks to the biological and social reproductive role conferred upon them. The institutionalisation of women's powerlessness in Sri Lanka in the context of women's health occurred both due to the longstanding 'beneficiary' ideology held by many women and the state's paternalistic approach towards women's issues. As discussed in Chapter 4, the rationale behind the state framing women's bodies during the 1990s was a particularly paternalistic attitude towards women subjects. This in turn precluded the state from perceiving women as citizens, creating an 'official impasse' to grant reproductive rights to them.

Leaving such contentious issues as marital rape, domestic violence and legalisation of abortion unaddressed, the state ostensibly designed the WWC programme around the notion of reproductive health. The WWC programme was launched as a screening mechanism to detect common non-communicable diseases among women over 35 years of age, conveniently ignoring the reproductive rights aspect of the ICPD resolution. Finally, the WWC programme became a half-realised dream of a post-Cairo women's health programme in Sri Lanka because reproductive rights were not incorporated. This was a result of state officials failing to see reproductive rights as human rights during the 1990s.

How successful was the concept of reproductive health introduced through the WWC programme in Sri Lanka? In order to understand how it was introduced and implemented, I interviewed policymakers of the FHB, implementers and 10 women in the two most attended WWCs —Attidiya and Kotalawalapura in Dehiwala, Western Province in Sri Lanka. WWC attendees were selected with the assistance of the midwives of these two clinics. They were from lower-middle class families and there was only one Muslim WWC attendee while the other nine were Sinhala Buddhists.

INTRODUCING REPRODUCTIVE HEALTH THROUGH WWCs

During the conceptualisation of WWCs, its architects identified three key components of the programme:

First and foremost, WWC is a women's clinic 'beyond reproduction'. Secondly, we wanted to introduce the idea of 'prevention' through screening. So

WWCs are for women to be screened periodically to detect common non-communicable diseases, such as cervical and breast cancer, diabetes and hypertension. Thirdly, we wanted to establish that WWCs are not to cure any disease but a clinic for healthy women.⁵²

According to this articulation, the WWC programme was clearly a step forward from family planning (which was essentially centred on population control) in Sri Lanka, towards a comprehensive women's health approach. Through my in-depth interviews with women attendees, I have explored how each of these three articulations gained meaning at the grassroots level, within the WWC programme.

WWC as a Clinic 'Beyond Reproduction'

'Beyond reproduction' is a novel concept not only within women's health discourses but also in discourses on women's bodies in Sri Lanka. As I mentioned in the introductory chapter, although Sri Lankan women have a commendable literacy rate, they were not emancipated through education because women's education was geared more towards producing 'presentable housewives'—a social reproductive role—than empowering women.⁵³ Education did not equip women with the essential tools to think 'beyond' the social reproductive role that they were traditionally bestowed with. A fifteenth-century Sinhala narrative poem *Kavyasekaraya*, written by Sri Rahula Thero of Thotagamuwa (which contains advice given by a noble father to his daughter before marriage), still continues to be included in the school curriculum, reiterating women's social reproductive role. Some of the advice proffered to women is to:

Be like a servant to your husband, his parents and his kinsmen; do not give anything away even to your own children, without your husband's consent; seek out your husband's desire in food and see that he is constantly satisfied, feed him and ensure his well-being like a mother.⁵⁴

This social reproductive ideology, which framed women's thinking and behaviour, was further defined by conferring another responsibility upon women: the national and cultural reproduction of the nation, from the period of British colonial rule through the nationalist struggles in Sri Lanka. As I mentioned in the Introduction, Anagarika Dharmapala was

a leading nationalist of the era who had a great impact on the lives of the rising Sinhalese middle class in the early twentieth century. Dharmapala introduced a new Sinhalese Buddhist lifestyle, and bestowed upon women a special and rather active role within the domestic sphere.⁵⁵ Housekeeping became a woman's key responsibility. The middle-class mother who attended to all the housekeeping and child-rearing duties was attributed with a holy status within the Buddhist revivalist ideology; she was considered the 'Buddha at home' (*Gedara Budun*).⁵⁶ Her parental responsibility was emphasised in the nuclear family unit, where the mother played the role of a teacher within the domestic sphere, cultivating social and moral values in children, while the father played a social role in the public sphere by providing for the family.

In this context, the health of the family was a prime duty of the wife and mother. As part of women's social reproductive role, Dharmapala advised women to see to the needs of all the members (including the servants) of the house; hygiene was also defined as a key responsibility, in order to ensure the smooth functioning of the home.⁵⁷ This ideology was further emphasised through the school curriculum. The health of the family lay squarely in the hands of women.⁵⁸ Though women in Sri Lanka were taught the importance of health and hygiene in school, they were not trained to attach the same importance to their own health because, as social reproducers, women were primarily care-givers to the family. Health education was provided to women because of their social reproductive role that entailed providing nutritious food and boiled water for the family, washing the clothes of the family, inculcating hygienic habits among children and keeping the house clean.⁵⁹ The WWC attendees that I interviewed mentioned most of these activities among their daily household chores, which I observed during these interviews. They also expected a girl child to learn these activities. Stressing how important it is to ensure that her children ate nutritious food, 43-year-old Lalani (Kotalawalapura WWC attendee) proudly said:

I still feed my daughter (23 years old) and son (21 years old) while they get dressed to go to work in the morning, if they don't have time to have breakfast. I make it a point that they don't eat junk food. In fact now, neither of them can tolerate fast food, it doesn't agree with their systems.⁶⁰

These interviews affirm that a biological and social reproductive role was clearly embedded within the educational and social upbringing of the girl child in Sri Lanka. Discourses on women's bodies are essentially framed around social reproduction, and this has to be taken into account when introducing the new shift in women's health, 'beyond reproduction'.

With this in mind, I will now address the way in which the public health infrastructure—that had been catering to a family planning agenda for more than three decades—geared itself to make this shift in Sri Lanka.

'BEYOND REPRODUCTION' WITHIN PUBLIC HEALTH INFRASTRUCTURE

I did not come across a single divorcee, widow or sterile woman in the WWC registers that both clinics have maintained since 2006. From my interviews with medical professionals attached to the public health sector, it was evident that women are counted and registered within the public health sector in Sri Lanka only when they start receiving ante-natal care at MCH clinics. This means that women become 'legible' in the state records/archive, or enter into official statistics, only through their active reproductive bodies. Because WWCs are placed within the MCH clinic premises, unmarried and sterile women cannot gain access to them; public health workers are unable to identify them since they are not listed in the MCH registers. Thus, unmarried and sterile women are excluded from this supposedly comprehensive new women's health initiative.⁶¹ Even though the stated aim of the WWC programme is to 'enhance women's health in Sri Lanka', placing WWCs in the MCH clinic premises had quite the opposite effect. It marginalised a section of women whose bodies were deemed unworthy of the attention of public health care purely because they were non-reproductive bodies.

Furthermore, divorced women were also excluded from WWCs. During my fieldwork, I learnt that the public perceive the MCH clinic as providing maternal and child health care, and often refer to them as 'family planning clinics'. Placing WWCs in that setting has resulted in misconceptions. One of my respondents, Kusum, a 43-year-old divorcee, pointed out that when she tried to go to a WWC with her cousin, her relatives said that:

People in the village will look at you in a suspicious manner. The MCH clinic is providing family planning service to the community no, so people will wonder why you are there. People will not bother to find out the real reason for your visit to the MCH clinic; instead, they will spread unnecessary rumours about you getting family planning treatment at the MCH clinic. So why do you want to invite unnecessary problems?⁶²

In the patriarchal society of Sri Lanka, women's lives are rigidly controlled by social values and norms. Thus, Kusum did not visit the WWC for a whole year. She attended the Kotalawalapura WWC only after much persuasion by one of her good friends. If a divorcee hesitates to attend a WWC in this context, then unmarried women are even more unlikely to attend, lest they arouse suspicion within the community that they are sexually active. Kusum's hesitation to attend a WWC points to the vexed connection between women's bodies, reproduction, and the controlling and planning ideology of women's health discourses in Sri Lanka.

After I interviewed Kusum, I questioned the officials about the decision to place WWCs in MCH clinic premises, referring to the statements made by my respondents. They explained to me that it was economical to have a family planning clinic and a WWC within the same premises since both clinics use similar equipment (such as speculums) and the same resources.⁶³ One official noted: 'Since family planning clinics are well-established across the country, it is cost-effective (in terms of getting water and electricity) to utilise the same premises rather than establishing a separate clinic.'⁶⁴ I was not surprised by this answer. In hindsight, I realised that the paradigm shift in women's health (that is, family planning to reproductive health and rights) is hard to implement in Sri Lanka due to a lack of resources. Officials opt to be practical instead of promoting the ideological shift that WWCs are supposed to bring in. Thus, leaving the ideology behind, WWCs were placed within the MCH premises. It is evident that the state (in this case, the FHB) was concerned only with *somehow* implementing the WWC programme, rather than realising the new ideology of women's health 'beyond reproduction' through WWCs.

These interviews affirm that there is a clear disconnect both at the policy-making and institutional levels. Having closely examined this problem, it is clear that both these disconnections stem from reading the discourses on women's health and women's bodies as separate entities,

territories and epistemes by disregarding the mutual inclusiveness of the two.

The second and third characteristics that the architects of the WWC programme articulated were that WWCs are to screen healthy bodies for common non-communicable diseases, and that WWCs are for healthy women. Since they are interlinked, I will explore these two articulations together.

WWCs are to Screen Healthy Bodies

The WWC programme proposes a process of screening and monitoring healthy, post-reproductive women's bodies as part of preventive health care.⁶⁵ Circulars clearly set out the idea that WWCs are for 'healthy' women by recommending WWC tests 'for any woman over 35 years'.⁶⁶ The PHMs are advised to educate and inform women in the area, with the help of field officers.⁶⁷ Screening is a new concept in the public health sector in Sri Lanka. Both Attidiya and Kotalawalapura PHMs expressed difficulty in articulating the idea of screening 'healthy women' for common, non-communicable diseases. One of the PHMs (Anusha from Attidiya) said that she could not convince her own mother, who is 55 years old, to undergo WWC tests. Her mother was embarrassed to show the private parts of her body to anybody, now that she was in her old age. In addition, her mother had said: 'It is not worth spending money on me even if I have a serious illness such as cancer, because I have lived my life, now it is your turn to live a good life.'⁶⁸ Another PHM, Pushpa, noted that her mother, who is 50 years old, had said:

It is a sin to let my unclean parts [*kili*] be examined by a male doctor. He [referring to the Medical Officer of Health] must be my son's age. By doing those tests [referring to the Pap smear test] I will prolong my sinful life and will definitely be a woman in my next birth also.⁶⁹

Even though Pushpa tried to explain that the doctor would be examining for a particular health condition and that he would not perceive it as an 'unclean part' since he is a professional, she failed to convince her mother. Clearly, if the Medical Officer of Health is a male, the older women find it difficult to attend the WWC. According to the cultural understanding

of women's bodies in Sri Lanka, all forms of cervical discharges are understood to be *kili*, meaning unclean/dirty.⁷⁰ Older women hesitate to allow the Pap smear test to be performed by a male doctor because they think that it is a sin to let a male doctor examine their body, particularly the vaginal area. In Sri Lanka, Buddhists generally believe that to be born male is more fortunate than being born female. They also believe in rebirth, the form of which depends on the *karma* done in previous incarnations.⁷¹ Women aspire to be born male in their next birth by being more respectful towards men in their current lives. By allowing a male doctor to examine her body, Pushpa's mother thought that she would accrue more sins in her present life and would be born a female in her next birth as well. Unlike the norm today, these women were helped in their deliveries by midwives, and now they feel uncomfortable and consider it a sin to be examined in the vaginal area by a male doctor.

Further, older women have a very different view of the preventive tests conducted at WWCs because such tests or body check-ups are unfamiliar concepts to them. Screening of healthy bodies is an innovative idea in Sri Lanka because it challenges previously held notions of health and women's bodies, which are interconnected with the traditional medical practices of Ayurvedic, Unani and Siddha systems, religion and women's position in the patriarchal household. Anthropologists who study notions of illness and sickness in colonial contexts perceive medicine as a part of culture.⁷² Interpretations of disease/illness and ailments originate from culture, because people view their bodies as part of culture and bodies are placed within culture. Though Western medicine, as a rational, scientific and institutionalised system, has all the necessary attributes for widespread acceptance, there are certain elements (especially with regard to women's bodies) which Sri Lankans constantly relate to culture, but which make no sense within science. For example, chanting the *angulimala piritha* during pregnancy in order to strengthen the pregnant woman and enable a smooth delivery is one such belief and practice.⁷³

According to the Ayurvedic medical system, sickness is a result of an imbalance in certain bodily components, referred to as *thriddosha*: *vatha* (wind), *pitha* (bile) and *sama* (phlegm). In order to maintain the equilibrium of these *doshas*, it is recommended that people eat healthy food, engage in physical exercise and practice certain bodily regulations.

These bodily regulations and food restrictions constitute the preventive aspects of the Ayurvedic medical system. Thus, people seek medical care only when they can no longer manage their bodies through this framework, and accept that they are sick. During my conversations with older women (mainly my interviewees' mothers or aunts), it was evident that traditional concepts of the body precluded notions that healthy bodies should be screened.

To be healthy meant not to be associated with clinics and medical care, in the reckoning of the lower-middle class women whom I interviewed. They were proud to say that they had not paid a visit to any medical setting during the last couple of years. During my conversations with the 59-year-old mother of one of my respondents, Wasana, the former said:

My husband and I have a good understanding about our bodies. Both of us do not seek medical help unless it is really necessary. Our lifestyle and eating habits have given us good health and we listen to the rhythm of our bodies.... Rhythm is what the body needs, for example, if I don't feel like having a bath today, I refrain from having a bath and if I feel like lying on the bed for some time I do so, because my body needs it. Nowadays, these children [pointing to Wasana] wash their hair just because they want to go out in the evening, without actually listening to what the body says. I think such practices cause unnecessary problems and health hazards. I think I haven't visited a doctor for more than three years now [a proud smile crossed her lips].⁷⁴

During the course of my research, I came across two distinct connotations of the concept of 'healthiness'. WWCs are introduced for 'healthy' women as a preventive measure in order to maintain their good health, while for many of my respondents, 'healthiness' meant keeping away from medical settings. During my fieldwork, I observed that people in general, and women in particular, seek medical help or advice only if they are evidently suffering from an ailment. These women try a range of home remedies prior to seeking medical help. For example, if they have a cough and cold, then they take *Koththamalli*, *pas panguwa* or *peyawa* (all consist of a decoction of herbs such as coriander seeds, *pathpadagam*, ginger, black pepper, *Venivel* and *Katuwelbatu*); for aches and pains in the knees and back, they apply *Siddhalepa* (a herbal balm) and take Panadol (paracetamol) or drink boiled garlic water. If, after two to three days of such treatment, the

ailment still persists, they seek medical help, most often from the nearby dispensary or government hospital at Kalubowila. However, WWCs are designed not for sick but for healthy women. Why should a woman go to a clinic or seek medical advice when she is feeling fine and healthy? There is a disconnect between the preventive approach of WWCs, such as screening and periodic body check-ups, and the general understanding of healthiness among the lower-middle class women who largely use public health-sector services in Sri Lanka.

Further, according to popular belief, cancer (breast cancer and cervical cancer are two of the conditions detected early through WWCs) is associated with 'karma' or '*Karuma leda*', which means that these sicknesses cannot be avoided since they occur either because of the sins committed by the afflicted in their previous births or because it is God's will. During my fieldwork, I encountered such beliefs in Buddhist and Muslim families. According to some of the Buddhists whom I interviewed, if a person had committed a sinful karma in a previous birth, then they must repay it by accepting the consequence, such as cancer.

When I asked 43-year-old Hareena (a Muslim WWC attendee in Attidiya, whom I spoke to on 23 March 2010 at her grocery shop) why her sisters and sisters-in-law had not attended the WWC, she said:

Unlike myself, they are devoted Muslims, so they will never go against God's wish. They believe that if a person has to suffer from a sickness, however much he or she tries, it is impossible to get away from it. You have to undergo the suffering.

In addition, she admitted that her views had changed radically in comparison to that of her own family members due to her exposure through her job at the Open University at Nawala, where she associated with people from diverse backgrounds.⁷⁵

Moreover, I also met women (mostly older women) who vehemently believed that there was no way they could be afflicted with cancer: the *Karuma leda*.⁷⁶ They believe that as they have led a just and peaceful life, there is no need for them to undergo WWC tests since they are certain that they will not suffer the illnesses screened for. These women have a specific understanding, perception and belief about themselves and their

bodies, which are closely associated with their culture, religion and life experiences. Unlike other clinics—such as ante-natal and post-natal, which address a specific condition—the WWC addresses women's health in a holistic manner. Thus, it is important that the designers of national programmes consider these women's specific language, beliefs, culture and perceptions of the body, instead of blindly following an international model constructed to eliminate non-communicable diseases. My interviews clearly point to a disconnect between the concepts promoted by the WWC programme, the state's framing of women's bodies in the 1990s and cultural understandings of women's bodies.

I will now consider the PRH policy of 1998 (another policy initiated as a consequence of the ICPD Cairo in 1994) in order to illustrate the inability of the state to conceptualise the shift in women's health—from controlled and planned women's health to reproductive health and rights. I argue that this inability resulted from the fact that the PRH policy was too inclined towards demographic targets. A Malthusian focus on population control emerged in new avatars, preventing a reproductive health and rights approach from becoming firmly established within women's health discourses.

POPULATION AND REPRODUCTIVE HEALTH (PRH) POLICY—1998

In tracing the history of population policy in Sri Lanka (in Chapter 1), I have shown that different nuances of meaning were attached to the population rhetoric of Sri Lanka at various moments in the history of post-independence Sri Lanka. The need for formulating a population policy was quite clearly stated in almost all the literature that I came across, although I did not find a concrete policy document until 1998: the Population and Reproductive Health Policy.⁷⁷ The PRH policy was initiated and supported by the population division of the Ministry of Health, and formulated within 12 months by a National Task Force. The policy was approved by the National Health Council on 23 December 1997 and by the cabinet on 27 August 1998.⁷⁸ This is Sri Lanka's only policy document on population, and it was formulated as a direct consequence of the ICPD. Therefore, it should clearly demarcate the shift (from family planning to reproductive

health and rights) in women's health proposed at the ICPD. However, the PRH policy, like the WWC programme, did not adopt the concept of reproductive rights. As I pointed out earlier, human rights were deeply undermined in 1990s' Sri Lanka, and in that context, there was no space for a reproductive rights discourse to germinate. Furthermore, the PRH policy was preoccupied with demographic goals, such as stabilising the size of the population by at least the middle of the twenty-first century.⁷⁹ In this context, the introduction of reproductive rights did not seem imperative.

Indeed, the PRH policy has adopted the meaning of reproductive health *exactly* (word for word) as it is outlined in the ICPD PoA, with a few changes to suit the Sri Lankan context. According to the ICPD PoA, reproductive health implies 'that *people* are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so [emphasis added]' (Chapter VII, Paragraph 7.2, Programme of Action, ICPD, 1994).⁸⁰

The PRH policy document replaced the 'people' in the ICPD PoA with 'couples'; and 'freedom to decide if, when and how often to do so' with 'freedom to decide responsibly on the number of children they may have'. It thus states:

Reproductive health therefore implies that *couples* are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide *responsibly on the number of children they may have* [emphasis added].⁸¹

These changes illustrate how influential Malthusian thinking was in the PRH policy, even at the supposed point of departure from a 'controlled and planned' programme to an emancipated women's health approach.

Instead of 'People', 'Couples' Were Adopted

Since children are typically conceived within the setting of a heterosexual nuclear family in Sri Lanka, the term 'couple' is used to denote parents (husband and wife). De Silva reminds us that single mothers and children born out of wedlock are very rare in Sri Lanka; thus, the PRH policy uses the term 'couple' (meaning husband and wife) in place of the term 'people' used in the ICPD PoA.⁸² Furthermore, the discourses on lesbian,

gay, bisexual, transgender, queer or intersex (LGBTQI) rights are limited to a very exclusive niche group in Sri Lanka. Sri Lanka refused to sign the December 2008 UN Declaration that urged member states to de-criminalise homosexuality. Homosexuality is a criminal offence under sections 365 and 365a of the penal code of Sri Lanka.⁸³ Even today, despite substantial pressure from the LGBTQI community in Sri Lanka, the state has refused to de-criminalise homosexuality. This demonstrates the state's inability to accommodate non-heterosexual forms of sexual orientation, and reveals the heterosexual nature of the state's ideology.⁸⁴ Given these facts, the 'couples' mentioned in the PRH policy are clearly those in heterosexual relationships.

By stating that 'couples are able to have a satisfying and safe sex life', the PRH policy addresses only heterosexual couples who are capable of bearing children. The PRH does not accommodate other forms of sexuality such as homosexuality and bisexuality, and excludes non-procreative bodies such as infertile or unmarried women because these groups do not impact the population growth rate. Not only is their sexuality muted, but also their right to health care is ignored within the public health care system by its exclusion from the PRH policy.

Instead of 'Freedom to Decide', Freedom to 'Decide Responsibly' was Adopted

What does the PRH policy mean by 'responsibly'? For whom are they responsible? As responsible citizens of the country, heterosexual couples are expected to reproduce according to their social and economic status in society. Referring to the post-ICPD Indian experience, Simon-Kumar says that neoliberal market forces convert citizens into 'ideological subjects' and make them believe that their relationship with the state is less about what 'rights' they can claim from the state and more about what 'obligations/responsibilities' they owe the state.⁸⁵ In the Sri Lankan case, I argue that it was not neoliberal market forces that influenced the formulation of PRH policy but deep-rooted state welfare policies in Sri Lanka. As I have pointed out earlier, because the state provides free health care to the public, state officials fail to see health as a right of the people; they continue to treat people as beneficiaries of the public health care system and to hold citizens

responsible for the health care they are given. Through logos and other published material, the state holds women responsible for the number of children they produce. Even though no number is explicitly mentioned (unlike, for example, the one-child policy in China), the two-child family norm was nevertheless established in Sri Lanka by the late 1980s through the dynamic family planning campaign under a former secretary of the Ministry of Plan Implementation, which I have discussed in detail in Chapters 1 and 2.

Moreover, by placing the term 'decide' parallel to 'responsibly', the empowering effect implied by the term 'decide' is diminished. Instead, the couple is bestowed with a responsibility towards the nation and the state, which urges them towards a two-child family norm. This process is reminiscent of the film *In Your Hands*, produced by the FPA in 1964, and the slogan '*punchi pavula raththaran*' (a small family is golden) used in the 1980s to convey the message that having a small family is part of the responsibility of every citizen to further the development cause of the nation.⁸⁶ Therefore, the sinews of the controlling and planning ideology of women's health are embedded in the PRH policy of 1998.

Instead of 'If, When and How Often To Do So', 'the Number of Children They May Have' Was Adopted

The PRH policy suggests that couples could decide responsibly the number of children they may have, not the number of children they 'want' to have. The whole notion of freedom that was proposed in the statement 'if, when and how often to do so' in the ICPD PoA is negated by its substitution with the 'number of children they may have' in the PRH policy. Moreover, it implies that the number is in fact decided for the couple by some external force, rather than by the couple themselves. The 'number' mentioned in the PRH policy is itself crucial because the ICPD explicitly rejected numbers and targets; it was a shift from 'an approach based on demographic targets to a comprehensive reproductive health approach', and from 'numerical quotas to informed choices'.⁸⁷ By stating that couples should 'decide *responsibly on the number of children they may have*', the PRH policy hints at the implicit coercion of the 'controlled and planned' ideology of the pre-ICPD era. Moreover, it confirms that, to use

S. Hodges' phrase, 'Malthus is forever' haunting the actions of the makers of the PRH policy in Sri Lanka.⁸⁸

Numbers and spacing of children are further stressed in goals one and two of the PRH policy document:

Goal 1 Strategies: Improve quality of service delivery to enable couples to decide freely and responsibly the number and spacing of their children.

Goal 2 Strategies: Promote family planning so that pregnancies do not take place too early in life or too late in life, are appropriately spaced and are not too many.⁸⁹

Goal 2 echoes the FPA slogan of the 1980s, 'not too many, not too soon, not too early, not too late'.⁹⁰ Even though the PRH policy attempts to advocate reproductive health, it nevertheless implicitly signals the number of children a family should have, and how important it is to space these children in order to produce a healthy future generation. Number and spacing were the linchpins of the Sri Lankan family planning programme in the 1980s. However, it seems that the same quantitative aspect of population resonated in different avatars well into the late 1990s, not least through the PRH policy.

As Betsy Hartmann correctly points out, the ICPD has taken out the 'hard core coercion' but brought back the 'soft sell strategy'.⁹¹ This is clearly manifested in the family planning incentives offered in Sri Lanka from the 1980s to the present day. These decisions are not only about a 'soft sell strategy', but also exemplify the elision of reproductive rights. By offering an 'out of pocket allowance' to the client and the medical staff and—to borrow a phrase from a government minister in the 1980s—'doling out' pills and condoms through PHMs, the government exercises indirect coercion, which in turn denies clients (mostly women) their reproductive rights.

Even though the PRH policy was designed as a consequence of the ICPD, it failed to address the core concept of the ICPD: reproductive health and rights free from any form of direct or indirect coercion. Thus, the PRH policy remains yet another half-realised dream of a post-ICPD women's health initiative in Sri Lanka.

The shift in women's health proposed at the ICPD—from family planning to reproductive health and rights—was not fully addressed by

either of these policies. According to my reading of these policies, and my interviews with the architects, implementers and users of WWCs, I attribute this shortcoming or failure to the inability of the state to read women's health discourses alongside the discourses on women's bodies in the 1990s. Since these two discourses were never read together or laid side-by-side in Sri Lanka, the new shift in women's health became a half-realised dream within the women's health discourses of post-independence Sri Lanka, just as in most of the other countries of the world.

NOTES

1. A. T. P. L. Abeykoon, 'ICPD 15 Years On: Sri Lanka's Participation, Policy and Programme Initiatives', in *ICPD*, ed. Weerakoon, p. 8.
2. *Annual Report on Family Health Sri Lanka 2004–2005*, Colombo, Family Health Bureau, 2007, p. 31.
3. *Population and Reproductive Health Policy 1998*, Colombo, Ministry of Health and Indigenous Medicine, Sri Lanka, 1998, p. 28.
4. S. Hodges, 'Review Article: Malthus is Forever: The Global Market for Population Control', *Global Social Policy* 10, 2010, p. 124.
5. See R. Simon-Kumar, 'Marketing' *Reproduction? Ideology and Population Policy in India*, New Delhi, Zubaan, 2006; S. Halfon, *The Cairo Consensus: Demographic Surveys, Women's Empowerment, and Regime Change in Population Policy*, Lanham/Boulder/New York/Toronto/Plymouth, Rowman & Littlefield Publishers, 2007; B. Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control*, Boston, South End Press, 1995 [1987]; S. Johnson, *The Politics of Population: The International Conference on Population and Development Cairo 1994*, London, Earthscan, 1995; R. Petchesky, 'Introduction', in *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*, eds Rosalind P. Petchesky and Karen Judd, London/New York, Zed Books, 1998.
6. Johnson, *The Politics of Population*, p. 17. (Though UN-sponsored population conferences were held before 1974, at Rome in 1954 and Belgrade in 1965, they were mainly scientific conferences where experts gathered to discuss the impact and implications of population.)
7. Simon-Kumar, 'Marketing' *Reproduction?* p. 5.
8. Halfon, *The Cairo Consensus*, p. 66.
9. Simon-Kumar, 'Marketing' *Reproduction?* p. 102; and Johnson, *The Politics of Population*, p. 18.

10. Johnson, *The Politics of Population*, p. 20.
11. By the early 1990s, reproductive-centred women's health had started to expand, especially in the US. 'The Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized the Centres for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program to improve access to screening services for low-income, uninsured, and other underserved women.' For details of the expansion of the definition of women's health, see C. S. Weisman, 'Changing Definitions of Women's Health: Implications for Health Care and Policy', *Maternal and Child Health Journal* 1 (3), 1997, pp. 179–89; see p. 182.
12. Simon-Kumar, 'Marketing' Reproduction? p. 2.
13. Halfon, *The Cairo Consensus*, p. 67.
14. *Ibid.*, p. 4.
15. R. Petchesky, *Global Prescriptions: Gendering Health and Human Rights*, London/New York, Zed Books, 2003, p. 35.
16. Hartmann, *Reproductive Rights and Wrongs*, p. 153.
17. *Ibid.*
18. Simon-Kumar, 'Marketing' Reproduction? p. 151.
19. B. Weerakoon, 'Introduction and Overview', in *ICPD*, ed. Weerakoon, p. xi.
20. *Suvanari Seva Athpotha* [Handbook about Setting up of WWCs], Colombo, Family Health Bureau, 2003, Preface.
21. M. Weerasooriya, 'Global Partnership for Population and Development', in *ICPD*, ed. Weerakoon, p. 69.
22. *Suvanari Seva Athpotha*, p. 1 (translation from Sinhala to English is mine).
23. J. P. A. Latour, H. Oxorn and N. W. Philpott, 'An Assessment of the Value of a Well Woman Clinic', *Canadian Medical Association Journal*, 67, 1952, p. 439.
24. *Ibid.*
25. K. Gardner, 'A Well Woman Clinic in an Inner-city General Practice', *Journal of the Royal College of General Practitioners* November, 1983, p. 711.
26. M. Manche, 'The Effectiveness of the Chester "Well-Woman" Clinics', unpublished MA thesis, Faculty of Medicine, University of Manchester, 1988, p. 1.
27. Gardner, 'A Well Woman Clinic', p. 711.
28. The Family Health Bureau (FHB) of Sri Lanka was set up in 1968.
29. General Circular No. 1926, 19 August 1996, pp. 1–2; translation mine.
30. Guidelines for Operationalising Well Woman Clinic Programme, circular dated 22 February 1997, p. 1.
31. These three circulars are: General Circular No. 1926, dated 19 August 1996; Guidelines for Operationalising the WWC Programme, dated 22 February

1997; and Guidelines for Implementation of the WWC Programme, dated 14 July 1999.

[I wish to express my gratitude to Dr Chithramali de Silva and Dr Sanjeewani Karunaratna of Family Health Bureau, Sri Lanka, for locating these documents for me. These circulars were addressed to all the key government officials in the public health sector.]

32. *Annual Report of the Family Health Bureau 2019*, Ministry of Health, Colombo, p. 1.
33. C. J. Wijesinghe, 'Descriptive Study on Women Attending WWCs in the Galle District', unpublished Ph.D. thesis, Postgraduate Institute of Medicine, Colombo, 2003, p. 8.
34. *Annual Report of the Family Health Bureau 2019*, Ministry of Health, Colombo, p. 79.
35. *Annual Report of the Family Health Bureau 2021*, Ministry of Health, Colombo, p. 19.
36. R. P. Petchesky, 'From Population Control to Reproductive Rights: Feminist Fault Lines', *Reproductive Health Matters* 3 (6), 1995, pp. 152-61.
37. R. P. Petchesky, 'Introduction', in *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures*, eds R. P. Petchesky and K. Judd, London/New York, Zed Books, 1998, p. 3.
38. Ibid.
39. *Annual Report of the Family Planning Association of Sri Lanka '97-'98*, Colombo, FPA, 1999, p. 24.
40. By 1995, the total fertility rate had come down to 1.9, which is below population replacement level. I have discussed details of the replacement level fertility in Chapter 2.
41. Johnson, *The Politics of Population*, p. 196.
42. Interview with the National Programme Manager, Gender and Women's Health (in-charge of the WWC programme) at the FHB, Colombo, 26 March 2010, at her office.
43. Critics of development aid programmes such as Bastian point out how development acquired different nuances due to these issues at the implementation level. See S. Bastian, *The Politics of Foreign Aid in Sri Lanka: Promoting Markets and Supporting Peace*, Colombo, International Centre for Ethnic Studies, 2007.
44. Since it is unusual for a historian to inquire about women's health policies, my questions were frequently met with such hostile responses from medical doctors in Sri Lanka.

45. Interview with the then WWC programme director of the UNFPA, 17 August 2011, at the UNFPA Colombo office.
46. Ibid.
47. Ibid.
48. R. P. Petchesky, 'From Population Control to Reproductive Rights', p. 153.
49. de Mel, *Women and the Nation's Narrative*, p. 235.
50. Goonesekere, 'Gender, Equality and the Empowerment of Women in Sri Lanka', p. 30. In fact, the criminal offence of abortion has existed unchanged in Sri Lanka since it was introduced to the penal code by the British in 1883 under section 303; see Penal Code of Sri Lanka, Chapter 25.
51. Hernes, *Welfare State and Woman Power*, p. 27.
52. Interviews with the National Programme Manager, Gender and Women's Health (in-charge of the WWC programme) at the FHB, Colombo, on 26 March 2010, at her office, and with one of the contributors for the *Suvanari Seva Athpotha*, lecturer at the Faculty of Medicine, University of Colombo, 30 March 2010.
53. Jayawardena, *Feminism and Nationalism*, p. 120; and Jayaweera (ed.), *Women in Post-Independence Sri Lanka*, New Delhi, Sage, 2002. I do not mean that the literacy rate reflects the level of education in a country. Of course, literacy and education are two different concepts, but the literacy rate is one of the main determinants that measures social development.
54. Jayawardena, *Feminism and Nationalism*, pp. 113–14.
55. 'Daily Code for the Laity' (*Gihī Dinacharyawa* in Sinhala), a pamphlet published by Anagarika Dharmapala in 1891, was an attempt to civilise the emerging Sinhalese middle class.
56. I have pointed out in Chapter 4 how this idea of *Gedara Budun* (Buddha at home)—the mother—and *Gedara Pradhaniya* (head of the house/family)—the father—is internalised through school education in Sri Lanka.
57. According to *Sigalovada Sutta* in *Digha Nikaya*, some advice that Lord Buddha gave regarding noble living was to take care of the employees and servants. Dharmapala's project is essentially a Buddhist project in modern times. <http://www.accesstosinsight.org/tipitaka/dn/dn.31.0.nara.html> (accessed on 21 August 2024).
58. This notion was propagated first by Anagarika Dharmapala in the pamphlet, 'Daily Code for the Laity', in 1891. Even today, the same ideology is transmitted through the school curricular.
59. Bjorkman argues that women's education in Sri Lanka has improved home hygiene and nutrition practices, thus ensuring reduced infant mortality and

prolonged life expectancy. The general understanding is such that even though women hold professional jobs, they should meet their social reproductive role as well. See J. W. Bjorkman, 'Health Policy and Politics in Sri Lanka: Developments in the South Asian Welfare State', *Asian Survey* 25 (5), 1985, pp. 537–52.

60. Interview with Lalani (WWC attendee), 8 April 2010, at her residence in Kotalawalapura.
61. Further, adolescent, geriatric and disabled are some of the other categories that are excluded from the women's health programme of Sri Lanka (*Women's Health Manifesto*, Colombo, SSA, p. 12).
62. Interview with Kusum (WWC attendee), 19 March 2010, at her residence in Kotalawalapura.
63. Interviews with the National Programme Manager, Gender and Women's Health at the FHB, 26 March 2010, Colombo, and a junior medical doctor working at the WWC division of the FHB.
64. Interview with a lecturer at the Department of Community Medicine, Faculty of Medicine, University of Colombo, who worked with the FHB on initiating the WWC programme, 30 March 2010, in his office at the Faculty of Medicine, University of Colombo.
65. The age of 35 years is regarded as the upper limit for bearing children in Sri Lanka.
66. Clause (2) of the Guidelines for Implementation of the WWC Programme, dated 14 July 1999, issued by the FHB, Colombo.
67. Guideline (5) of the General Circular No. 1926, dated 19 August 1996.
68. Interview with Anusha (PHM), Attidiya, 23 March 2010.
69. Interview with Pushpa (PHM), Attidiya, 23 March 2010.
70. During menstruation, women do not step into a kovil (temple). Even though worshipping a god is historically a Hindu tradition, today it is a Buddhist practice as well.
71. For a detailed anthropological analysis of different ritual and worshipping practices and beliefs of Buddhists in Sri Lanka, see K. Malalgoda, *Buddhism in Sinhalese Society 1750–1900: A Study of Religious Revival and Change*, Berkeley, LA, London, University of California Press, 1976; R. Gombrich and G. Obeyesekere, *Buddhism Transformed: Religious Change in Sri Lanka*, Princeton, NJ, Princeton University Press, 1988; S. J. Tambiah, *Buddhism Betrayed? Religion, Politics and Violence in Sri Lanka*, Chicago, University of Chicago Press, 1992; S. Wickremaratne, *Buddha in Sri Lanka: Remembered Yesterdays*, Albany, State University of New York Press, 2006; P. D. A. de Silva, 'Anthropology of Sinhala Buddhism', *Contemporary Buddhism: An*

- International Journal* 7 (2), 2006, pp. 165–70; and J. Uyangoda, *Religion in Context: Buddhism and Socio-Political Change in Sri Lanka*, Colombo, SSA, 2007.
72. A. Kleinman, *Writing at the Margin; Discourse between Anthropology and Medicine*, Berkeley, Los Angeles and California, University of California Press, 1995, p. 8.
 73. According to Buddhist *Jathaka Stories*, Angulimala Thero had helped a pregnant woman during her delivery; so when the delivery date draws near, it is a practice in Buddhist households today to invite monks to chant *Angulimala Piritha*.
 74. Interview with Wasana's mother at her residence in Kotalawalapura, 8 April 2010. Wasana is my interviewee (WWC attendee).
 75. She left the job after the third child was born and now runs a grocery shop together with her husband.
 76. Mothers of my respondents, with whom I had a chat during my field visits.
 77. Despite the success story of Sri Lanka in curbing population growth rates.
 78. *Population and Reproductive Health Policy 1998*, p. 37; and Abeykoon, 'ICPD 15 Years On', p. 8.
 79. *Population and Reproductive Health Policy 1998*, p. 27.
 80. *Population and Development: Programme of Action adopted at the International Conference on Population and Development*, Department of Economic and Social Affairs, United Nations, 1995. p. 30.
 81. *Population and Reproductive Health Policy 1998*.
 82. W. I. de Silva, 'Correlates of Marital Postponement in Sri Lanka', *The Journal of Family Welfare* 46 (2), 2000, p. 42.
 83. http://www.glapn.org/sodomylaws/world/sri_lanka/sri_lanka.htm (accessed on 21 August 2024).
 84. India de-criminalised private, consensual sex between adults of the same sex on 2 July 2010. Sri Lanka has still not taken any affirmative action in this regard. For the current status of LGBT rights in Sri Lanka, see <http://groundviews.org/2010/07/07/celebrating-a-lesbian-gay-bisexual-transgender-inquiring-and-queer-sri-lanka/> (accessed on 21 August 2024).
 85. R. Simon-Kumar, 'Neo-liberal Development and Reproductive Health in India: The Making of the Personal and the Political', *Indian Journal of Gender Studies* 14 (3), 2007, p. 367.
 86. *Annual Report of the Family Planning Association 1963–64*, Colombo, FPA, p. 10.
 87. Petchesky, *Global Prescriptions*, p. 35; and Simon-Kumar, 'Marketing' *Reproduction?*, p. 6.

88. By reviewing Hartmann, Connelly, Halfon, Rao and Simon-Kumar, Hodges points out how Malthus is ever present in the framing of population policies in the Third World. See Hodges, 'Review Article'.
89. *Population and Reproductive Health Policy 1998*, pp. 29–30.
90. *Annual Report of Family Planning Association 1980*, Colombo, FPA, 1981, p. 10.
91. Hartmann, *Reproductive Rights and Wrongs*, p. 153.

Conclusion

At the outset, I stated that my intention was to write a critical history of women's health in modern Sri Lanka. In fact, Sri Lanka's women's health statistics are remarkable compared to most other countries in the region. Internationally renowned demographers, development economists and public health experts hailed Sri Lanka as a 'development model' by the 1970s for her decreased fertility and mortality rates, high female literacy levels, women's empowerment and a sound public health care service. Since population is seen within the development discourse as one of the primary determinants of development, women's health emerged as the main development indicator within the state-building project of independent Sri Lanka. Thus, women's health served as a linchpin to the attainment of this 'success story'. Although development experts, economists and demographers have been comfortable with this 'success story' based on statistics and indicators, as a woman historian with a critical mind, I found it problematic. Because the woman's body is the ground on which women's health policies are implemented, I believe her corporeal experiences and the related discourses on the woman's body play a significant role in women's health. In fact, I was interested in exploring what these statistics did not and still do not say. I found Foucault's approach towards history writing the best method to pursue this task: by 'disturbing and questioning the tranquillity' with which this 'success story' is accepted and has become commonsense knowledge in Sri Lanka.

In critical history writing, 'success stories' are considered problematic as they are built on pillars of subjugation and silence. As historians, we know that the emergence of one story means that there are several other

simultaneous subjugated stories which were not given adequate attention in traditional history writing. My interest lies in these subjugated stories because they elucidate a broader insight into the larger picture and also how power relations work between various actors in society. With this aim in mind, I have approached the woman's body through her corporeal experiences and discourses on the woman's body which were framed through nationalist discourses during the colonial and post-colonial periods in Sri Lanka. I placed both 'women's health' discourses and discourses on the 'woman's body' within a unified analytical framework to bring out these subjugated stories. By doing so, I was able to provide a wider lens to comprehend women's health and this in turn became the basis of my writing of a critical history of women's health in post-independence Sri Lanka. My research showed that women's health statistics have become so dominant in explaining this 'success' that they have managed to mask the processes that were muting and silencing women's bodies—both their individual and collective corporeal experiences.

MAIN CONTRIBUTIONS

As a piece of original research, this book has made both conceptual and analytical contributions to the area of women's health in Sri Lanka. By unearthing the subjugated stories of the woman's body, I was able to provide a different reading to twentieth-century women's health in Sri Lanka. By highlighting primary sources and reading the archival material against the grain I was able to provide a new analytical framework for women's health in Sri Lanka.

Conceptual Contribution

Instead of reading women's health through statistics, I have attempted to conceptualise women's health in post-independence Sri Lanka through subjugated stories of women's corporeal experiences and discourses on the woman's body. I deployed multiple methods such as archival research, in-depth interviews and oral histories to explore these subjugated stories. By doing so, I was able to place discourses of women's health and discourses of the woman's body within a single analytical framework.

Women's health discourse in Sri Lanka is predominantly a territory confined to policymakers, medical professionals, demographers and economists. In contrast, the discourses on the woman's body seem to be a territory largely confined to the attentions of feminist social scientists. These two groups in Sri Lanka did not dare to leave their epistemic province. As a historian, I trespassed these boundaries between women's health and women's bodies. It was indeed a challenging experience to trespass into others' epistemes. However, it gave me the opportunity to understand how global population debates are being played out in a Third World country, how international funding for population control works, how power works in the health sector in Sri Lanka, and how academia and policymakers work within the broader framework of global health. Because I moved from the medical faculty of Colombo University to Indigenous Medical Faculty to FPA (an NGO) to FHB and then to the public health-sector workers at the grassroots level to women recipients of health policy in Sri Lanka, I was able to gather a number of different perceptions, experiences and stories. Of course, these stories did not relate a linear sequential order of events. Sometimes they related opaque and contradictory stories and at other times they related very similar stories. By listening to them very carefully and referring to historical evidence from numerous archives, I was able to bring out the subjugated stories of women's health. I earnestly hope that the new approach that I propose—to place women's health discourse and discourses of the woman's body in a single analytical framework—will help to do justice to women's health by having a holistic inquiry in the future.

Further, after ending a 26-year-long ethnic conflict, I believe that this is the right moment to release the woman's body from the nation-building project of post-independence Sri Lanka and empower women by granting them reproductive rights. This is the right moment to challenge the national responsibilities that the woman's body has carried so far and to create a new empowered individual human body for women.

The chapter about the Pill trials in Ceylon is a new contribution and addition not only to the local understanding of the introduction of the Pill to Ceylon, but also to the global Pill history. It analysed how global Pill trials were conducted in South Asia and also why Ceylon became part of it in 1961. Through the correspondence that I unearthed in the US

between Pincus, pioneers of family planning and Chinnatamby, I showed how Ceylon entered into a discourse on modernisation through the Pill trials. As Chinnatamby's personal records were not available in Sri Lanka, my investigation into and analysis of her personal correspondence with pioneers in oral contraception was a noteworthy attempt to introduce the discipline of history of medicine to Sri Lanka. My analysis of politics and the funding of clinical experiments of the Pill gives a broader picture of the Third World contribution to a pioneering modern scientific product. Further, my investigation into the Pill trials in Ceylon gives a new turn to family planning and women's health history writing in Sri Lanka. This is because so far, women's health had projected a 'success story', but now, by taking the discourses on the woman's body within the same analytical framework, I have created new avenues to write women's health history in Sri Lanka by challenging the linear history writing tradition.

Further, through my analysis of the programme of social marketing of contraceptives in 1974, I showed how women's health and bodies became the ground on which market forces (*Mithuri*) replaced ethnic forces (*vanda beheth/pethi*) in Sri Lanka. It further established the importance of bringing both the women's health discourse and discourses on woman's body into a unified analytical framework.

I have contributed to history writing on women's health in post-independence Sri Lanka by introducing new analytical categories such as 'beyond reproduction'. By analysing the broader economic, social and political milieu in the 1990s, I showed how the state deployed women's health and bodies to maintain the 'model' status of South Asia.

With the aforementioned approaches and analysis, this book has made an earnest effort to provide a different reading to Sri Lanka's women's health 'model status' that is essentially different from readings of the history of family planning, development and population control.

Analytical Contribution

According to my analysis of the public health welfare policy of Sri Lanka, the state makes women mere beneficiaries of women's health schemes, creating a certain paternal tutelage. As mentioned at the beginning, within the state-building process of post-independence Sri Lanka, women's health

became the linchpin of the state's strategy. With the aim of keeping the population growth rate under control, the state regulated the woman's reproductive body by implementing a welfare policy for women's health. On the one hand, this prolonged welfare approach towards women's health has made women dependent on the state. On the other hand, the state has conveniently ignored that health is a human right and a responsibility of the state towards its citizens. Thus, the state provided, and still provides, health care to women beneficiaries, not to women citizens. My research, especially through the interviews that I had with policymakers and recipients of public health policy, made evident that this dependent mentality of women and the state's inability to regard women as its citizens have heightened the extent of paternal tutelage in Sri Lanka. As a consequence, the state treats women as mere beneficiaries of public health care, further disempowering them of their right to health care and their own bodies.

The state's deployment of the woman's body in nation-building in the 1950s, economic development in the 1980s and in safeguarding the state in times of intense conflict in the 1990s further tightened its grip on the woman's body. This in turn became a burden on her biological and social reproductive role, disallowing her to think about her body 'beyond reproduction'. When the ICPD proposed to conceptualise women's health within a reproductive health and rights framework in 1994, the state could not possibly do so due to this grip that it had on the woman's body. Through a careful reading of post-ICPD health policies (WWC policy and PRH policy) and in-depth interviews with WWC policymakers and attendees, I have shown that Sri Lanka was able to implement the reproductive health component of the ICPD framework but had failed to address the reproductive rights component. The term 'reproductive rights' was not mentioned in any of the WWC policy documents. Thus, ICPD became a half-realised dream in Sri Lanka and this, in turn, made Sri Lanka depart from the long-held women's health 'success story' by the mid-1990s.

In fact, I have not only challenged the women's health 'success story' by bringing forth the other stories of the woman's body, but I have also proved that Sri Lanka had failed to uphold its success story by the mid-1990s.

Epilogue

Sri Lanka was aiming to become the ‘emerging wonder of South Asia’ after ending the 26-year ethnic conflict in 2009 through a military defeat. Upon my arrival in Colombo in July 2009 after six months in the UK during the initial stages of my Ph.D. studies, seeing the barricades removed from the high security zones in Colombo indeed projected a sense of freedom which I had never before experienced in my life. When the ethnic conflict started in 1983, I was in primary school and throughout my teenaged years and youth, I experienced the conflict in the form of bomb explosions, shootings and suicide bombings in Colombo, where I lived, and which was a non-war zone. Walking down the roads of Colombo in July 2009 without being stopped to have my identity card checked and questioned about my whereabouts was indeed a new experience. Colombo looked like a completely new and spacious city. The high walls of the national archives, Cinnamon Gardens Police Station and several other government buildings in Colombo were replaced with fences to reveal the sprawling green lawns of these buildings, making one massive open park with clearly demarcated walking and cycling paths. These changes in creating open spaces instead of barricades and security check points (especially in the government building premises) offered a new sense of closeness/understanding between the public and the state. It looked as if the autocratic state that crushed the Liberation Tigers of Tamil Eelam (LTTE) had taken a human face with an approachable countenance. The sense of freedom that I experienced in this new landscape was too much to bear. Can this be real? Are we (women) really free from violence and discrimination? And, most of all, since the ethnic violence is over, are women free from being reproducers of the nation?

I started my fieldwork in Sri Lanka in mid-2009 with much enthusiasm, thinking that it was the right moment to start imagining women as humans and citizens of Sri Lanka, released from the national reproducer role that they had been bestowed with from colonial times. But soon I realised that it was a fantasy. During my interviews with officials of the Family Health Bureau (FHB) and Family Planning Association (FPA), these initial feelings of emancipation dripped little by little in front of the stark reality of the 'controlling and planning' mind-set of the officials in charge of women's health. Their attitude towards women as beneficiaries of the public health care system of the state made me realise that the battle in hand is not going to be easy.

I was told off frequently by the officers of the FHB (medical doctors), family planners (especially gynaecologists) and demographers for trying to find answers to a wrong set of questions. Since all these officials are heavily influenced by Malthusian ideas on population growth, my questions on women's health discourse (not women's health as a 'controlled and planned' practice) and the global debates on eugenics, birth control, family planning, the Pill trials, and reproductive health and rights seemed to disturb the women's health 'success story' that they faithfully believed in and are working on. In fact, that was their basis as well as their comfort zone, so my questions disturbed and irritated them at the same time.

President Mahinda Rajapakse in his first budget speech (after ending the ethnic conflict) 'proposed to give cash assistance of Rs. 100,000 (£ 555) for a live birth of the third child in the families of armed force personnel, to promote their family environment'.¹ Clearly, the President's proposal calls for two distinct aspects that eugenics is operating within: quantity and quality. The proposal suggests increasing the number of children (quantity), but at the same time hints at the quality by being specific about 'families of armed force personnel'. The majority of the military forces are Sinhalese, which means he hints at two eugenic components: ethnicity and bravery/physical fitness. Lara Marks reminds us that during the inter-war years, various countries in Europe as well as the US were also promoting more births among the 'fit' and the healthy within the nation, and this was known as 'pronatalism'.² Further, as mentioned in Chapter 5, from November 2010 the Ministry of Health had decided to distribute oral contraceptive pills and condoms free of charge due to the rise (2.3 per

cent) in the total fertility rate.³ Then why did the state encourage a third child from soldier families and distribute the Pill and condoms free of charge to others? Even though family planners hesitate to see any eugenic inclination in the family planning programme in Sri Lanka, what else could be more eugenic than this proposal, which was introduced exactly after the 26 years of ethnic violence came to an end? This clearly shows that, instead of releasing women's bodies from the role of reproducer of the nation, the Sri Lankan state tightened its grip on women's bodies by placing a monetary value on her reproductive body for producing brave Sinhalese children. Where is the 'model' of South Asia heading with these new policy initiatives? Is it heading for a comprehensive women's health approach as proposed by the ICPD or embracing a new avatar of Malthus?

Through writing a critical history of women's health and bodies in modern Sri Lanka, I attempted to problematise and (if possible) answer the larger issues of women's health in Sri Lanka by placing women's health and the woman's body discourses in a unified analytical framework. By doing so, it became clear that although women's health was vigilantly 'controlled' and 'planned' for the state-building project and women's bodies were framed around the notion of social reproduction for the nation-building project of modern Sri Lanka, women were neither subjects nor objects of these two projects. Women's reproductive bodies were rather the ground for a complex and competing set of struggles on population, family planning, development, modernisation and ethno-nationalism in independent Sri Lanka.⁴ Further, an analysis of women's health/women's bodies' helps to elucidate the manner in which we can track the operation of power that serves to silence women's own corporeal subjectivity and to delimit the realms in which she can exercise her own agency.

Even though I tried to answer a wrong set of questions (according to demographers and family planners), if veneration of motherhood continues like this in Sri Lanka, it will open another set of new questions in the near future that demographers and development experts will struggle to find answers to. There is a trend of women giving up their jobs to fulfil their maternal duties (when their children start schooling) in Sri Lanka. This is reflected in statistics as women's participation in the labour force is the lowest in Sri Lanka among the countries of the region.⁵ Then what is the dividend that the state receives by investing in women's education?

Does that mean the aim of women's education has shifted from producing a 'presentable housewife'⁶ to a 'good mother'? The premise of both these roles is social reproduction. Then can we still call Sri Lanka a land of women's empowerment? These are larger issues beyond the scope of this study. But these looming issues make my argument—of freeing women's bodies from the national reproducer role and creating a human rights/citizenship discourse—ever so pertinent today for the future of women in Sri Lanka.

The seed of this book germinated when my body was challenged by the Western medical practice of Sri Lanka. So this is my fight to create space for women's bodies within the women's health discourse of Sri Lanka.

I have penned down a few words below to my *chuti duwa* (little daughter) about my fears and hopes about her future in Sri Lanka.

LETTER TO MY DAUGHTER

To My Dearest *Chuti Duwa*

I have started the fight for us to win our share of human rights (not women's rights) free from national reproductive obligations. I see that you are getting carefully ingrained into the same veneration of motherhood that I went through in the same school thirty years ago. I do not want to confuse you now by refuting those ideas that you learn in school, but I will talk to you about them when you are a little older and ready.

Do you have any real understanding of what I have been doing here in England, leaving all of you behind? I know you will only remember these years (from 2009 to 2013) as: amma (mother) was away to pursue higher studies or to get a PhD. But actually my love, it was not only a PhD to me but part of my fight in creating a starting point for a new imagination of human rights through releasing women's health from state building and women's bodies from the nation-building of Sri Lanka.

I never agreed to the concept of women's rights (though it is what feminists of Sri Lanka are fighting for) because I always saw me (and still see me) not particularly as a woman, but as a human being. So I do not see the necessity in fighting for the rights of one group of people by excluding the others. And in the same way, I do not see why a mother should be more important in a child's life than the father. I think both are equally important figures in

a child's life and also parenting is the responsibility that both share, not as maternal or paternal duties. I think you experienced that perfectly well, especially during my long absences in your childhood.

I know it is very hard to change an ideology, in particular a one like 'Gedara Budun'. But we must deconstruct it, just as it was constructed during nationalist struggles in the colonial period. Now the ethnic tensions have subsided, so it is time for us to imagine and write a history of the present Sri Lanka by keeping the term nationalism out of the historians' vocabulary. That is the only way that we can disentangle women's bodies from nationalism and project our bodies as human bodies; nothing less, nothing more. Does it sound scary, my love? Do you think it is going to be a very tough fight?

Well, remember, only if you imagine... you will be able to dream. Only if you dream you could make it happen. So my love, do not ever stop imagining.

With all my love

Amma

NOTES

1. <https://www.tamilguardian.com/content/sri-lankan-budget-continues-payments-soldiers-have-third-child> (accessed on 24 August 2024).
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4. In here, I echo Mani's analysis of sati. L. Mani, *Contentious Traditions: The Debate on Sati in Colonial India*, Berkeley, CA, London, University of California Press, 1998, p. 2.
5. <https://www.ips.lk/talkingeconomics/2017/07/27/women-in-the-sri-lankan-workforce-dissecting-education-and-female-labour-force-participation/> ('Talking Economics', the blog of the Institute of Policy Studies of Sri Lanka [IPS], Sri Lanka's apex socio-economic policy think tank. Accessed on 24 August 2024).
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