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WOMEN IN THE PATRIARCHAL WELFARE STATE

Darshi Thoradeniya*

Colombo Branch of the South Asia Institute, Heidelberg University, Germany

ABSTRACT

This essay analyses the implications of the state performing a welfare function for an extended period of time in relation to the social contract between women citizens and the state. It argues that a prolonged status of 'welfare provider' ascribes certain patriarchal attributes to the state, which in turn reduces the position of the citizens, especially women, to a mere 'beneficiary' level. With the use of two specific policy documents relating to public health – Well Woman Clinic (WWC) programme launched in 1996, and the Population and Reproductive Health (PRH) policy designed in 1998 – it shows that in the absence of a rights based approach to public health, women have become mere beneficiaries, as opposed to active citizens, of the prolonged welfare State of Sri Lanka. This relationship has deterred women citizens from exercising the right to demand their needs from the State.

Keywords: Welfarism, Social Contract, Women Citizens, Sri Lanka, Reproductive Health

INTRODUCTION

This essay attempts to engage critically with a discourse on welfarism in Sri Lanka. Welfare state is a form of administration/government in which the State plays a key role in the protection and promotion of economic and social well-being of its citizens. In other words the State becomes in-charge of providing the basic needs of the people. When the State performs this responsibility for decades, the State looms as a patriarch to its people/ beneficiaries, especially to women (see Seccombe 1974, Dalla Costa and James 1975, and Eisenstein 1978). Within such a patriarchal welfare State what happens to the social contract between the State and woman citizen? Do women citizens have a bargaining power/mechanism or exercise any right to demand their needs from a patriarchal welfare State? What is really at stake within this patriarchal relationship? In short, will there be citizens in a patriarchal welfare state,

*Author e-mail
darshi@sai.uni-heidelberg.de
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let alone women citizens?

Even though welfare state policies deal with provisions of education, health care, housing and a well administered system of food security, in this paper I will tackle the above questions in relation to public health policies in Sri Lanka. I will look at two specific policy documents on reproductive health (i.e. Well Woman Clinic (WWC) programme launched in 1996, and the Population and Reproductive Health Policy (PRH) designed in 1998) which were adopted in response to the International Conference on Population and Development (ICPD or Cairo) held in Cairo in 1994 to analyse the relationship between the welfare State and women in Sri Lanka. 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 (Abeykoon 2009). How did this rights based approach reflect in the social contract between the welfare State and women beneficiaries of public health in Sri Lanka?

The first section of the paper gives a brief historical background of the welfare states in the world and welfare policies of Sri Lanka. With that understanding I have moved on to an analyze of two policy documents on reproductive health to illustrate how Malthusian thinking/ideology was imbedded in these policies. Taking the Sri Lankan political context of the 1990s (specifically human rights violations) into consideration I have shown how the WWC programme and PRH policy failed to initiate a discussion on reproductive rights. By doing so I conclude that, in the absence of a rights based approach to public health, women have become mere beneficiaries, as opposed to active citizens, of the prolonged welfare State of Sri Lanka.

HISTORICAL BACKGROUND OF WELFARE STATE POLICIES OF SRI LANKA

Welfare state policies were introduced to Sri Lanka through the British colonial regime in the early 20th century (along with constitutional reforms in 1932) with the introduction of public health (Jones 2002). The roots of public welfare go back to the 1830s where the modern British state intervened with issues related to destitution, sickness and squalor which were largely the result of the Industrial Revolution. In other words welfare did not have a clear existence before the emergence of the modern state (Hewitt 1983). Scholars studying colonial societies have pointed out that the colonial administrations worked towards disciplining the subjects/people/colonial bodies through the introduction of Christianity and luxury consumer products such as soap, cologne and powder. In order to 'civilise' the 'savage', the colonial administration introduced public health through Western medicine, and education through missionary schools (See Chatterjee 1993; McClintock 1995; Mohanty 1991; Jayawardene 1986; De Alwis 1996, 1997, 2004; De Mel 2004, 2007; Managuru 1995; Ismail 1995; and Stoler 1989).

Analyzing Foucault's reading of social policy and welfare, Hewitt (1983) perceives the role of social policy as a 'co-ordinating role, in forming 'the social'. It promotes and organizes knowledge, norms and social practices to regulate the quality of life of the population – its health, security and stability' (p. 67). By doing so social welfare policies 'regulate the unproductive in disciplinary institutions such as schools, factories and prisons and sanitise the living conditions of the general population through public health' (p. 67-68). In other words the State deploys welfare policies to organize knowledge,

norms and social practices in a particular way to get maximum productivity of the able population.

With decolonization after the Second World War, former colonies worked towards developing their countries and establishing their new national identities. Welfare policies seemed the best method to deploy people towards the development of the State/Nation. Population was carefully monitored, controlled and planned through health policies. By the late 1950s Sri Lanka invited renowned Swedish economist Gunnar Myrdal and his team to design a national development plan for Sri Lanka. The Ten Year Plan of 1959 was the outcome of this invitation. In the post-war global context Sweden emerged as a neutral country in Europe (with absolutely zero involvement in both the world wars) and was a great proponent of the welfare ideology. Thus Gunnar Myrdal as an economist and his wife Alva Myrdal as a social reformer came to assist South Asian governments on their national development projects. According to Gunatilleke (2005) post independence Sri Lanka was a 'benevolent welfare State' providing social services to its needy population. Since the coverage of these services was universal, it did not have the social stigma of poor relief and was regarded as the entitlement of citizens (Gunatilleke 2005). By the 1970s, internationally renowned demographers, development economists and health experts 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 (Kirk 1969; Caldwell et al 1989; Alam and Cleland 1981). Indeed State welfare policies that were carried out through national development plans improved the living conditions of the people. With improved living conditions development indicators of the country improved and consequently people became mere beneficiaries of the welfare State while making the State a patriarchal welfare State. How long should people be 'beneficiaries' of the State? Would beneficiaries talk about their needs and rights and start a dialogue with the State? Would the State instigate a dialogue with 'beneficiaries' of its welfare services? What will happen to the social contract between the State and people with this lengthy period of 'beneficiary–ness'?

Patriarchal Welfare State

A number of Scandinavian studies have been done on the relationship between the welfare state and women in the 1970s and 1980s, which I found useful in my analysis of the patriarchal nature of the Sri Lankan welfare state. Leira (1992) notes that a number of feminist scholars, such as Seccombe (1974), Dalla Costa and James (1975), and Eisenstein (1978), conceive of the welfare state as 'patriarchal' and inherently oppressive because it organises social reproduction in such a way by assigning childcare and upbringing to women. They see it as a perpetuation of men's dominance and women's subordination (Ibid). In her analysis of women's status as citizens, clients and employees of the state, Hernes (1984) argues that the welfare state exercises some form of 'tutelage' towards women in its policies. Contesting this interpretation, Siim (1984) contends that the welfare state forms a partnership with women in social reproduction (as cited in Leira 1992). 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 (Ibid). 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. The welfare state's patriarchal attitude and responsibility as the provider of free education and health services has made the Sri Lankan state acquire a form of paternal tutelage towards women. This could be seen especially regarding women's issues, such as family planning, contraception and nation building.

Identifying the nature of the Sri Lankan State, I'll turn to the two reproductive health policies that were designed in response to the ICPD held in Cairo in 1994 to explore the relationship between the State and women citizens in Sri Lanka.

WELL WOMAN CLINIC PROGRAMME OF SRI LANKA – 1996

Well Woman Clinic Programme was launched in Sri Lanka in 1996 with the aim of addressing a global paradigm shift in women's health –from family planning to reproductive health and reproductive rights. 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 (Weerakoon 2009, p. xi).

In line with this paradigm shift, the WWC programme was introduced as a reproductive health initiative to address women's health 'beyond reproduction' (Suvanari Seva Athpotha 2003). 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 (Weerasooriya 2009). The government's stated aim in launching its WWC programme was to introduce the concept of reproductive health in order to enhance women's health in Sri Lanka. *Suvanari sayana kanthavange saukya thathvaya nagasituveema aramunukaragena prajanana saukya sankalpaya yatathe kriyathmaka karanalada nawa sayanika sevavaki* (Suvanari Seva Athpotha, p. 1. Translation from Sinhala to English is mine).

The WWC programme came under the auspices of the Family Health Bureau (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.[1] The stated objective of the WWC programme was,

Avurudu 35ta vædi kanthavan muhunapæ hæki pradhana rogithathvayan kihipayak handuna gæneemen 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) (General Circular, 1996 Aug. 19, p. 1-2).

As in the West where it originated, WWCs were set up in Sri Lanka within the sphere of preventive medicine as 'screening centres' and not centres for treatment (Guidelines for Operationalizing Well Woman Clinic Programme, 1997Feb. 22, p. 1).

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.[2] 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 280 health units in Sri Lanka headed by a MO/MCH carrying out preventive care services (De Silva 2007).[3] The first WWC was set up in June 1996 in the Kalutara District in the Western Province of Sri Lanka (Wijesinghe 2003). By the end of 2007, 611 WWCs were functioning in the country, based mostly at pre-existing MOH health centres (Annual Report on Family Health Sri Lanka 2006-2007, 2009, p. 21). The number of women attending the clinics increased from 61,707 in 2004 to 113,712 in 2007 (Ibid, p. 22). However, the FHB notes that only 18 percent of women who attend were over 35 years of age.[4]

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. Didn't the State see health as a right of women in Sri Lanka?

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. When the State provides health care as a welfare service for decades, the social contract between the two parties (the State and women in this instance) transforms from a service provider-citizen to a donor-beneficiary relationship. The following section deals with a critical analysis of reproductive rights in the State rhetoric of women's health.

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 (Global Health Watch 2005-06 Report). Petchesky (1998) points out that women's rights movements in both the global North and South developed and expanded the concept of reproductive health and sexual rights through 'cross fertilisation of ideas –across many countries and continents' (p. 3) during the 1990s. They were brought onto international platforms at the World Conference on Human Rights in Vienna in 1993, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 (Ibid).

Even though the Annual Reports of the Family Planning Association (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 (Annual Report of Family Planning Association'97-'98,p. 24). 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 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,so that by 1996 the state could claim that population was no longer a 'problem' for development.[5] 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 percent, the total fertility rate was 2.2 and the life expectancy for women was almost 75 years' (Johnson 1995, p.196). 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, 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 thirty-five years of age, conveniently ignoring the reproductive rights aspect of the ICPD resolution. The WWC programme, therefore, became a half-realised dream of a post-Cairo women's health programme in Sri Lanka because reproductive rights were not incorporated. This was the result of State officials failing to see reproductive rights as human rights during the 1990s.

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.' (Interview with the National Programme Manager Gender and Women's Health [in-charge of WWC programme] Colombo, 26 March 2010). 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.[6] 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 honourable Minister of Health and Nutrition Mr. 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 was 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 WWC 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 the WWC programme then?] to the present WWC programme director of the UNFPA, she evaded the question by saying that, 'it is a chicken and egg situation.' According to her, I was asking the wrong set of questions.[7] 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 (Interview with the WWC programme director of the UNFPA, 17 Aug. 2011).

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 healthcare sector (Ibid). 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 (Ibid).

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.

From my conversations with officials at the FHB and the UNFPA, it is clear that both these institutions (FHB and the UNFPA) 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 reckon 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 in possessing the best women's health indicators in the region. In their eagerness, these 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 necessity by the State and also there was not any demand for such a right from women.

Reproductive Rights as an 'Official Impasse'

I see this omission of reproductive rights as an 'official impasse' wherein the State was incapable of producing a reproductive rights discourse at a time when human rights were undermined by the State. Analysing the Cairo Programme of Action, Petchesky (1995) points out that reproductive rights (in a very broad sense) are defined by and linked to fundamental human rights. In the absence of a situation where Sri Lankans enjoyed fundamental human rights, it is hardly surprising that in the 1990s women's

reproductive rights (that is the right to make decisions about one's reproductive body free from direct or indirect coercion) were not 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 (De Mel 2002, p.235). 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 (Goonasekere 2009, p. 30).[8] This confirms that it was absolutely not possible to instigate a discussion on reproductive rights within 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 'never 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 welfareism in Sri Lanka has made women beneficiaries of the public health system, which in turn has made them indebted to the State for what they are receiving free of charge. Consequently, they became beneficiaries of State welfare services and ignorant of their rights as citizens of the State. In other words the social contract between women and the State became a beneficiary-donor relationship. In her analysis of the importance of social welfare policies for the lives of Scandinavian women, Hernes (1987) 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 (p. 27).

From my interviews, it is clear that their prolonged 'beneficiary' status caused the powerlessness of women to be institutionalised. This situation further deteriorated 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. This in turn precluded the state from perceiving women as citizens, creating an 'official impasse' to grant reproductive rights to them.

POPULATION AND REPRODUCTIVE HEALTH (PRH) POLICY - 1998

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.[9] 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 PRH policy was approved by the National Health Council on 23rd December 1997 and by the Cabinet on 27 August 1998 (Population and Reproductive Health Policy 1998 ; Abeykoon 2009). 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 above, 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 next century (Population and Reproductive Health Policy 1998, p. 27). 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 Programme of Action, with a few changes to suit the Sri Lankan context. According to the ICPD Programme of Action, 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 mine) (ICPD Programme of Action 1994, Chapter VII, Paragraph 7.2).

The PRH policy document replaced the 'people' in the ICPD Programme of Action 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"(Population and Reproductive Health Policy 1998, emphasis mine).

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' was 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 (2000) 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 Programme of Action (Ibid). Furthermore, the discourses on lesbian, gay, bisexual and transgender (LGBT) 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 Section 365 and 365a of the Sri Lankan Penal Code ('Penal Code' 2004). Even today, despite substantial pressure by the LGBT 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.[10] 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. By adopting the term 'couples' and excluding other forms of sexualities the State's donor attitude towards welfare services emerges very sharply in the PRH policy document.

Instead of 'freedom to decide', freedom to 'decide responsibly' was Adopted

What does the PRH policy mean by 'responsibly'? To 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 (2007) says that neo-liberal 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 than what 'obligations/ responsibilities' they owe the state (p. 367). In the Sri Lankan case, I argue that it was not neo-liberal market forces that influenced the formulation of PRH policy but deep-rooted state welfare policies in Sri Lanka. As I have pointed out above, because the State provides free health care to the public, state officials fail to see health as a right of the people anymore; 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.

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 (Annual Report of the Family Planning Association 1963–64). Therefore, it can be said that the sinews of the controlling and planning ideology of women's health are embedded in the PRH policy of 1998. Although the ICPD promoted women's empowerment through reproductive rights, the Sri Lankan State was unable to capture the 'reproductive rights' ideology in its PRH policy of the 1990s. Furthermore, major violations of human rights during this period prevented the state from addressing the reproductive rights of women.

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 Programme of Action is negated by its substitution for 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" (Petchesky2003, p. 35; Simon-Kumar2006,p. 6).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 Hodges' (2010) phrase, 'Malthus is forever' haunting the actions of the policy makers of the PRH policy in Sri Lanka.[11]

Numbers and spacing of children is 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 (Population and Reproductive Health Policy 1998, p. 29-30).

Goal 2 echoes the FPA slogan of the 1980s, 'not too many, not too soon, not too early, not too late (Annual Report of Family Planning Association 1980, 1981, p. 10). 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 resonates in different avatars well into the late 1990s, not least through the PRH policy.

As Hartmann (1995) correctly points out, the ICPD has taken out the 'hard core coercion' but brought back the 'soft sell strategy' (p. 153). This is clearly manifested in the family planning incentives offered in Sri Lanka from the 1980s to the present day. Despite the PRH policy, the FHB still makes a payment for sterilisation: LKR 500 (GBP 2.39) for the client and LKR 65 (GBP 0.31) to the medical doctor and PHM (General Circular No. 01-09/2007 on 'Payment for female/ male sterilizations' of the FHB, April 3,2007). This amount has been consistent from the 1980s. Furthermore, addressing the rise in total fertility rates (2.3 according to Sri Lankan Demographic and Housing Survey 2006/2007) from November 2010, the Ministry of Health has decided to distribute oral contraceptive pills and condoms free of charge (General Circular No. 01-39/2010 on 'Removal of fee for Oral Contraceptive Pills (OCP) & Condoms' November 2 2010). Both these decisions not only reflect 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 and makes them beneficiaries of State welfare.

Even though the WWC programme and PRH policy were 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.

CONCLUSION

Sri Lanka has been a welfare State for almost eighty three years. Within such a lengthy time span any concept would and should transform, change, adapt and reform to economic, social, political and other changes in society. Through two public health policies of Sri Lanka (i.e. WWC Programme and Population and Reproductive Health Policy) I attempted to understand in this paper the transformation of the social contract between the welfare State and women.

After becoming a 'development model' for South Asia by the 1970s, the welfare State of Sri Lanka seemed to assume a patriarchal responsibility towards the people, especially women, through maternal and reproductive health policies. This relationship deterred women citizens from exercising their right to demand their needs from the State. Consequently it made women mere 'beneficiaries' of the patriarchal welfare State. On the other hand the State loomed as the 'donor' of welfare services, creating a disproportionate power relationship in the social contract between the State and women.

In line with the neo-liberal market forces in the 1990s, ICPD broke away from controlled and planned reproductive policies and embarked on reproductive health and rights. The focus became a rights based approach as opposed to the coercive target-based approach. Even though Sri Lanka ratified the programme of action of ICPD, the welfare State failed to bring in a reproductive rights discourse through the public health sector. Apart from being a war torn society where priorities were forfeited, I attribute this failure to the failed social contract between the State and women over the years. State's status as the 'donor' of welfare services pushed women to a 'passive beneficiary' status. There is very little space for a beneficiary to demand their rights. As a consequence I argue that women cannot be considered as citizens of the State anymore, but mere beneficiaries of the prolonged welfare State of Sri Lanka. This contention demands a redefinition of welfare State policies in such a way to have a healthy social contract between the State and women citizens.

NOTES

1. Family Health Bureau (FHB) of Sri Lanka was set up in 1968.

2. These three circulars are; General Circular No. 1926 dated 19th August 1996, Guidelines for Operationalising the WWC programme dated 22nd February 1997 and Guidelines for Implementation of the WWC programme dated 14th July 1999. [I wish to express my gratitude to Dr Chithramali de Silva and Dr Sanjeewani Karunarathna 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.]

3. The first Health Unit was set up in Kalutara in 1926 and the second in Weudawili, Hatpattu in the North Western Province in Nov. 1927, and the third in Matara in the Southern Province in May 1928 (Uragoda 1987, p. 163).

4. WWCs are operated in four settings in Sri Lanka. They are at MOH health centres and government base hospitals offering free medical services to the public. Private hospitals and private institutions geared towards health and wellness offer different health packages to undergo tests done at WWCs. Apart from these institutions the FPA of Sri Lanka established a WWC in December 1997 within its reproductive health initiative. Since the majority of the population depend on public health services in Sri Lanka and also because I am analysing government policy documents I have limited my study to the government WWC programme and the beneficiaries of the government health care system.

5. By 1995 Total Fertility Rate has come down to 1.9, which is below population replacement level.

6. Critics of development aid programmes such as Bastian (2007) point out how development acquired different nuances due to these issues at implementation level.

7. Since it is unusual for a historian to inquire about women's health policies, I frequently encountered this type of hostile responses from medical doctors in Sri Lanka.

8. 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. More information can be found athttp://www.commonlii.org/lk/legis/consol_act/pc25130.pdf ("Penal Code" n.d.).

9. Despite the success story of Sri Lanka in curbing population growth rates

10. India de-criminalised private, consensual sex between adults of the same sex on 2nd 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/ ('Celebrating LGBT and questioning Sri Lanka 2010).

11. By reviewing Hartmann, Connelly, Halfon, Rao and Simon-Kumar, Hodges points out how Malthus is ever so present in the framing of population policies in the third world. See Hodges, 'Review Article: Malthus is Forever (2010).

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