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Sandya Hewamanne
University of Essex

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Emergency Contraceptives are our Saviors: Sri Lanka's Global Factory Workers Negotiating Reproductive Health

By Sandya Hewamanne¹

Abstract

Government agencies, NGOs and medical personnel profess competing perceptions on Sri Lanka's female Free trade Zone (FTZ) workers' reproductive health needs. Varied statistical sources also present and interpret the overall reproductive health outcomes for FTZ workers in differing ways. In this extraordinarily saturated field of power, where different agents and agencies jostle for legitimacy to speak for female global factory workers, the overarching question is where the women workers themselves stand? How do they perceive and respond to discourses and practices within this field? What are their experiences of reproductive health and knowledge and how have their attitudes changed over time? Based on 15 in-depth interviews with workers and a reproductive health survey of 100 workers, this paper seeks to answer these questions. The analyses are also informed by numerous interviews with NGO staff, government officials, health professionals and educators. \

The continuing cultural restrictions and resultant practices of denial and silence surrounding premarital sex render contraceptive usage an "after thought," leading to workers believing that emergency contraceptives alone allow them agency when managing reproductive choices. While the number of agents and agencies vying to speak for workers' reproductive rights has increased, nothing much has changed for workers at the ground level, making them marginal actors in these discourses and policy-wars. By demonstrating that workers are neither ignorant about reproductive technology nor naïve about the difficulties encountered when exercising their reproductive rights, I argue that their choice of morning-after pill and abortions is, in fact, a critique of the actors and agencies who represent and advocate for FTZ workers based on their own particular agendas.

Keywords: Reproductive health, Emergency contraceptives, Global factory workers, Sri Lanka, In-depth interviews.

Introduction

In July 2018 Nitha, an NGO staff member agitatedly complained that the chief nursing officer of the Katunayake Medical Health Office (MHO), located within the Katunayake Free Trade Zone (FTZ), refused the educational services the Family Planning Association of Sri Lanka

¹. Sandya Hewamanne is professor of Anthropology, Department of Sociology, University of Essex. She is the author of *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*, University of Pennsylvania Press (2008) *Sri Lanka's Global Factory Workers: (Un)Disciplined Desires and Sexual Struggles in a Post-Colonial Society*, Routledge (2016) and *Re-stitching Identities in Rural Sri Lanka: Neoliberalism, Gender and Politics of Contentment*, University of Pennsylvania Press (2020). She has published numerous journal articles and book chapters on labor and human rights, gender, sexuality and economic anthropology. She is also the Convener of Essex South Asia Research Network (ESARN) and the Founder, Director of IMPACT-Global Work, a non-profit which connects academics and activists to initiate beneficial policies for global workers in third world countries.

(FPASL) offered because, according to her, the FTZ did not have a reproductive health crisis and the MHO office efficiently managed FTZ workers' needs. "They speak nonsense while women die at illegal roadside abortion clinics," Nitha protested.

The officials at the FPASL (a semi-government institution receiving both government and international donor funds), I interviewed in 2018 strongly held that female FTZ workers needed to have more knowledge of contraceptives and increased accessibility. However, government health staff had a different view. When I interviewed the chief nursing officer at the FTZ'S MHO office, she painted a rosy picture of the reproductive scene by claiming women workers easily talked with her staff about contraceptives and other pregnancy related issues. Yet, as per Dabindu, an NGO working among FTZ workers, even married women refrained from raising their hands when asked who was sexually active during one of their workshops that the chief nurse also attended. However, right after the workshop a number of these women called anonymously to seek advice on sexual matters they were unwilling to discuss at the workshop.

While agents and agencies hold competing perceptions on female FTZ workers' reproductive health needs, different statistical sources also present and interpret the overall reproductive health outcomes for Sri Lanka in differing ways. The 2018 FPASL report notes that the need to reach out to young people with comprehensive sexual and reproductive health education is greater than ever and is an area in which the "country as a whole is lagging behind" (15). It further notes that the FPASL is gradually relocating their clinics "to the industrial zones in Sri Lanka, where you find pockets of underserved young people" (11). The Sri Lanka Demographic and Health Survey (SLDHS) report of 2016 claims that Sri Lanka has seen a revolution in reproductive health, given that "one of the most significant positive changes in the history of empowering women that occurred in the latter half of the 20th century was opening up avenues for women to choose whether and when to have children. The 'Reproductive Revolution' was made possible by the availability of a wide range of modern contraceptive methods...." (51). Interestingly, however, SLDHS only focused on ever married women to provide the statistics and analyses. In a country where premarital sex is still considered taboo, this focus on married women's contraceptive usage speaks volumes about the way cultures shape what statistics get collected and how they are interpreted (Harnois and Hewamanne 2020).

Obviously, this is an extraordinarily saturated field of power where different agents and agencies jostle for legitimacy to speak for female global factory workers. But where do the women workers stand in this field? How do they perceive and respond to discourses and practices within this field? What are their experiences of reproductive health and knowledge and what are their hopes and expectations for the future? Based on 15 in-depth interviews with workers conducted in 2017 and a reproductive health survey of 100 workers conducted in 2015, this paper seeks to answer these questions. My analysis below is also informed by numerous interviews with NGO staff, health professionals and educators. Furthermore, the new data is juxtaposed with the data that formed the basis for my 2006 article (Author) to show new developments and continuities.

After locating this paper within existing literature and discussing methods, I will briefly recount the global workers' reproductive knowledges and experiences from 2000-2005. The next section analyzes the current workers' reproductive experiences in detail. In doing so I argue that the continuing cultural restrictions and resultant practices of denial and silences surrounding premarital sex renders contraceptive usage an "after thought." I further argue that while the number of agents and agencies vying to speak for workers' reproductive rights has increased, nothing much has changed for workers at the ground level and that they remain marginal actors in these discourses and policy-wars. Hence workers' choice of emergency contraceptives and abortions as

the best methods to exercise agency in reproductive choices is a critique of this field of power. The paper further argues that without a living wage that enables workers to live with dignity, educational programs alone become meaningless exercises.

Negotiating Reproductive Health in Developing Countries

Reproductive health experiences are not divorced from the socio-economic structures and cultural ideologies within which people negotiate complex lives. A woman's ability to decide for herself whether, when, if and with whom to have sex and children is a fundamental right. However, studies show that notions of individual freedom do not always translate into local practice and the ability to make reproductive choices is deeply affected by patriarchal power relations (Ginsburg and Rapp, 1991; 1995; Blanc, 2001; Denno, 2015; Chandra-Mouli et al, 2018). Thus, it is important to study reproductive health within the broader social, economic and political contexts that shape reproductive behavior (Ginsburg and Rapp, 1995; Mullings and Wali, 2001; Ali, 2002; Author 2006; 2016).

As the United States grapples with changing state laws on abortion rights and facilities, Donald Trump's policies are severely restricting the mandate and funding of Planned Parenthood, thereby causing detrimental chain effects on reproductive health efforts in developing countries. The right-wing political upswing globally has given rise to protests such as the MeToo movement and women's marches. But their influence on countries like Sri Lanka is limited to elite and middle-class women. In the meantime, the budget cuts to planned parenthood is having devastating effects on the already bleak situation concerning reproductive health of global factory workers. It is established that family planning services should be part of any strategy to improve women's health and well-being. Apart from improving maternal and infant health, family planning empowers women to fully engage in socio economic activities, which improves living standards for families. Thus, it is crucial that women have affordable access to multiple forms of contraceptives such as the pill, injectables, intrauterine devices (IUD), condoms and sterilization. Women in most developing countries, however, do not have a satisfactory range of affordable contraceptive methods to choose from (Mbizvo and Phillips, 2014). Although modern contraceptive usage is increasing, in 2014 there were 225 million women with unmet need for contraceptives. Of this number, 34% were located in South Asia (Singh et al, 2014; Darroch and Singh, 2013). The effects of budget cuts to planned parenthood will be felt in the years to come in South Asian countries like Sri Lanka.

Studies have shown that even when a range of contraceptive methods are available, cultural perceptions of virginity, sexual passivity and other sexual mores can affect reproductive decision-making (Dansereau et al, 2017; Kabagynei et al, 2016). These accounts underline the effects of cultural perceptions on women's ability to acquire reproductive health information and stress the need for service programs to address the power relations that can be an obstacle for women acquiring such information. Work on Sri Lanka also focuses on lack of knowledge and access to information and services in explaining reproductive problems (Bujawansa, 2002; Ratnayake, 2002; Jordal et al, 2014; Pethiyagoda, 2018). Many such studies stress the need for more educational programs and counselling to minimize reproductive health problems (Hettiarachchi and Schensul, 2001; Agampodi et al, 2008; DeGraff and Siddhisena, 2015). Studies of other countries in South Asia also emphasize the lack of access to information and the need for more educational programs (Srikanth and Reid, 2008; Sheik and Loney, 2018).

In her essay on abortion discourses in Sri Lanka, Wickramagamage (2000, p. 11) points out that even when information on contraceptives is freely available, culture-induced inhibitions may nevertheless prevent women approaching institutions providing such information and support. Hettiarachchi and Schensul's (2001, pp. 137–8) work on reproductive health among Sri Lanka's FTZ workers concludes that reproductive dilemmas stem from the limited knowledge of poor rural women who work in the FTZs, and they emphasize the need for more health education programs and counselling services for workers. Hewamanne (2006) argued that the FTZ workers do have more than average awareness of all aspects of reproductive health and services but are hindered in their efforts to access contraceptives due to cultural inhibitions and particular practices of public and private sector vendors influenced by the dominant culture. Hewamanne further argued that the constructed 'disrespectability' of FTZ workers affect the power imbalances within relationships and hinders reproductive negotiations (2003; 2006; 2016). Jordal et al (2014; 2015) extends this finding by focusing on how constructions of women's respectability affect Sri Lanka's FTZ workers' negotiations within intimate relationships.

A slew of studies on abortion decision making in Sri Lanka has evidenced that young women understood abortion as unsafe, yet the lack of easily accessible contraceptives, and resultant unwanted pregnancies, pushed them toward having abortions (Olsson and Wijewardena, 2010; Arambepola et al, 2014). Writing about the use of emergency pills, Mbizvo and Phillips note that they can be effective in preventing pregnancy when other methods were unavailable, forgotten or a woman was not able to negotiate contraceptive use. They further call for the availability and access of such emergency contraceptive methods in developing countries, especially in the context of post-rape care, gender-based violence and inaccessibility (2014, p. 933).

Different stake holders such as FPASL, the government health officials and NGOs in and around the Katunayake FTZ differently perceived reproductive health standards and contraceptive accessibility among global factory workers. They all wanted to represent workers' reproductive health situation—either positively or negatively. The interviews and survey demonstrated that women's reproductive experiences are more complicated than 'unmet needs' or 'reproductive revolutions' and that they themselves were highly conflicted about their needs and moved amongst ideological and practical positionings depending on the context and their life cycle stage. Studies in many other developing countries have shown that educational and awareness programs are only part of a comprehensive intervention to improve reproductive health (Delendhorf et al, 2014). A long-term strategy of changing cultural attitudes and assumptions about gender and associated sexual inequality between men and women need to be combined with accessibility to a range of affordable contraceptive methods and counselling on contraceptive negotiation. Following a brief discussion on FTZ workers and methods, I evaluate existing cultural assumptions and attitudes and how they affect reproductive decision making among global factory workers.

Free Trade Zone and Global Factory Workers

Sri Lanka established its first FTZ in Katunayake, as part of a newly elected government's open market policies that envisioned transnational production leading to development via trickledown economics. Katunayake is located 35 kilometers northeast of Colombo and is home to Sri Lanka's premier international airport. Most FTZ workers have migrated there from economically stagnant areas in North Central and Southern Provinces. Although increasing numbers of young Tamil women from the Eastern Province have begun working in the FTZ since the island's civil war ended in 2009, majority of workers still hail from North Central and Southern

Provinces of the country.² The assumption that such rural women, lacking alternative choices and being merely supplementary wage earners, would accept employment under any condition resulted in difficult target-oriented work conditions, and minimal wages. In 2019, over 40 years after the Katunayake FTZ was established, basic worker salary was Rs. 13,000 (about US\$ 80) per month, although women could earn about Rs. 25,000 by working overtime and foregoing annual leave. As in other transnational factories around the world, Katunayake factories demand maximum output for minimal wages amidst exploitative working conditions. About 45,000 rural women from economically and socially marginalized groups work as machine operators in the FTZ's 92 factories and a similar number work for subcontracting factories located around the zone. Most are unmarried, young, and well-educated, often with 10-12 years of schooling (Hewamanne 2019; 2020a).

There are few state or factory-run hostels; instead, women mainly make do by renting rooms locals have hastily and poorly built. The difficult work and living conditions are compounded by the sexual harassment workers face on city streets and the shop floor (Hewamanne 2012; 2016). Furthermore, intense anxieties about their mobility create an image of FTZ workers as loose women who can be easily deceived into sexual relationships. Consequently, accounts relating to premarital sex, rape, prostitution, abortion, and infanticide portray these women as victims of labor and sexual exploitation and their own loose morals.

At the same time, living with other young women in an urban area causes these women to undergo social, cultural, emotional, and cognitive changes. For instance, they start to value relative freedom of movement and new lifestyles; they acquire global knowledge flows including discourses of reproductive rights; and the intense socialization process in factories and boarding houses encourage them to dress, behave, think, and desire in new ways. Ultimately, as industrial workers at transnational factories and unmarried daughters of patriarchal villages, FTZ workers straddle varied cultural discourses and the way they negotiate reproductive health decisions display the ambivalences created by this particular positioning.

Methods

This research is based on 15 in-depth interviews with FTZ workers conducted in 2017 and to a lesser extent a survey on reproductive health among 100 FTZ workers conducted in 2015. The 15 interviewees were chosen randomly from 10 boarding houses, each housing 50-60 workers. The only stipulations were that they be between 20-30 years in age and were migrants from a rural area. Among a massive number of qualified workers, the 15 were selected based on the duration of stay, availability and willingness to be interviewed. They have, by their own admission, taken part in the 2015 survey. The survey was administered to 100 randomly chosen workers residing in the same 10 boarding houses. The questions were on their sexual and reproductive health knowledge, their perception of contraceptive access and abortion. They were asked to not include their names or any other identifying information and to drop the completed questionnaires in a locked box through an opening. Only the researcher had the key to this box. Sixty-one questionnaires were returned.

² The majority of Sri Lankans are Sinhala (74.9) while Sri Lankan Tamils comprises of 11.2%, Indian Tamils 4.1% and Sri Lanka Muslims 9.3%. Out of the total population, 70.1 percent are Buddhists, 12.6 percent are Hindus, 9.7 percent are followers of Islam, 7.6 percent belong to Roman Catholics and other Christian denominations. (Department of Census and Statistics, Sri Lanka: 2012).

The in-depth interviews provided much data and ranged in time from 95- 150 minutes, while 8 women met a second time to complete the interview. I have conducted research in the Katunayake FTZ area since 2000 and make research visits every summer (and sometimes in December). I had previously visited all 10 boarding houses and was therefore familiar with most of the residents. Being a woman of their own ethnicity, religion and also speaking their own language helped immensely in building rapport with the workers.

Educated Women and Reproductive Crisis-2000-2005

These big fat women (middle class women's organization members) think that we are ignorant fools. We know all about contraceptives and sexual health. Let them come and learn from us.

--A FTZ worker at a boarding house in 2000

Why do we need to know about contraceptive methods or safe sex behavior? We are unmarried women (therefore not having sex).

--An FTZ worker talking about their HIV/AIDS vulnerability in 2004

My 2006 article on reproductive health among FTZ workers started with these two contradictory statements. This contradiction was well replicated in the reproductive health scenario at the time with women claiming and demonstrating a high standard of knowledge of contraceptive methods even as stories and official reports of unwanted pregnancies, abortions and infanticide frequently circulated in the area. Successive police officers in the area claimed that the most difficult aspect of their job was to deal with conflicts arising from abandonment due to unwanted pregnancies, illegal abortion clinics and incidents of infanticide (Hewamanne, 2016). Clearly, the factory workers who claimed that they knew about contraceptives and where to obtain them were not using contraceptives when having sex. Research showed that while workers were reasonably knowledgeable, as unmarried women they lacked cultural permission to start using contraceptives. The taboo on premarital sex made both men and women perform the expected roles of 'good young people' who must ideally wait till marriage to engage in sex. Women were burdened by cultural expectations that promoted sexual ignorance before marriage and shy, timid behavior befitting sexually passive young women. Young men in the meantime were taught that initiating a shy virgin into sexual pleasures is the foundation of an ideal relationship.

According to Obeyesekere (1984, pp. 504–5), Sinhala children are socialized into practices of shame-fear (*lajja-baya*)—to be ashamed to subvert norms of sexual modesty and proper behavior and to fear the social ridicule that result from such subversion—from a young age. When women started migrating to cities for FTZ work, it was the impact on their *lajja-baya* that the middle-class and males feared most. Romanticized notions of superior morals and undisturbed traditions in Sri Lankan villages were superimposed on women, initiating expectations that village women are naïve, innocent (in the sense of being sexually ignorant) and timid and that they are the unadulterated bearers of Sinhala-Buddhist culture.

However, in the FTZ, rural women encountered new global cultural flows and acquired new knowledge. They consequently developed strong community feelings and actively engaged in a transgressive subculture (Hewamanne 2003; 2008). Living away from their families and engaging in harsh assembly line work at global factories, women workers found some solace by

entering into romantic relationships with young men who frequented the area. Although both parties attempted to perform ideal gender expectations, as young people it was inevitable that they would engage in sexual relations. The NGOs in the area and the FPASL targeted FTZ women workers from the very early days of global factory production for educational workshops. These workshops added more knowledge to what workers have already gathered from secondary schools and media. However, most women workers I interviewed claimed that sex acts happened at unplanned moments when neither of the partners had contraceptives with them. This corresponded with cultural pressures, where men and women sought to act as ideal young people by pretending that they did not want sex before marriage. Thus, when they faced unplanned circumstances, like when a bus broke down and they had to spend the night at an abandoned building or rooming house, unprotected sexual intercourse ensued. Even the few instances when women claimed that they willingly engaged in sex, none used contraceptives lest they came across as being prepared and eager. Some women went on to have regular sexual relations yet ended up with unwanted pregnancies due to myths their male partners held about contraceptives, and women's inability to negotiate safe sex without antagonizing the partner. Cultural expectations again influenced this decision to not antagonize unreasonable partners, as society valorized virginity at marriage and these women who have now lost their virginity felt pressured to hold onto the men they first had sex with.

Thus, even when they did possess sexual knowledge, the interviewees felt they had to pretend otherwise, lest they came across as 'sluts' for having gained sexual knowledge before marriage. All agreed that women were expected to be reluctant to have sex, and to be seduced and gently pushed to have sex. They also noted that while men may like women who are sexually aggressive for fun, they would not think of getting married to such a woman. In fact, interviews with men in the area confirmed women's perceptions. A man who wrote to one of the tabloids about his relationship noted how he was disgusted beyond belief when he found that his girlfriend had contraceptive pills hidden in a secret panel of her handbag, and how he immediately terminated the relationship with her (Hewamanne, 2006).

In 2000-2004 the workers' own ideas showed that the normalized dominant cultural expectations of innocence, virginity and norms of shame-fear discouraged women workers from practicing their newly acquired knowledge on reproductive health to negotiate contraceptive use within relationships. It also showed that men in the area considered FTZ workers to be unsheltered and showed them little respect due to their stigmatized jobs and substandard boarding houses. In short, the low wages and resultant unsafe accommodation facilities normalized everyday violence against them.

Reproductive health is not just about women and their bodies but includes communities, networks, and the socio-cultural and political structures within which sexuality is negotiated.³ In order to become agents shaping their own reproductive futures, women needed a different kind of knowledge – one that helps them overcome cultural constraints and allows them to pursue choices that matter to them—and an environment where they can achieve dignified livelihoods. Thus my 2006 article concluded that the need is for women workers to gain skills in applying their knowledge of reproductive technologies as they negotiate activities enmeshed in issues of love,

³ This was brought home to many Sri Lankan Muslim women after the infamous Easter bombings in Sri Lanka on April 21, 2019. The discourses surrounding the ethnic-religious divide and global terrorism that followed the Easter tragedy quickly converged on Muslim women's attire, bodies and reproductive choices and lack there-of, fueling new political demands and counter demands on women's bodies and behaviors.

intimacy, respect and trust. The following section investigates the current reproductive health narratives within the Katunayake FTZ area to explore the continuities, changes and future needs.

Since 2006 up until 2017- Massive changes

The evidence from 2006 showed that women's employment in transnational factories and their subsequent exposure to new ideas and resources, especially regarding reproductive health, did not lead toward agency that helped women shape their own reproductive futures. Sri Lankan society generally and FTZ employment specifically have seen massive changes since the early 2000s, and these warrants revisiting the reproductive health scenario among global factory workers. For instance, Sri Lanka's 25 year long civil war ended in 2009 and the island has witnessed a boom in the construction and tourist industries. The end of the civil war has also allowed labor recruiters to target Tamil women from war torn areas for work in the Katunayake factories. This together with more casualization of factory work has led to an increase in day labor hiring through agencies. During the time between 2006-2015, Sri Lanka lost and regained the GST+ benefits.⁴ The Multi Fiber Agreement (MFA) was phased, which ended the quota system in apparel manufacturing and gave rise to fears of job losses. In response the government and apparel manufacturers' association launched a "Garments without Guilt" program to certify better labor standards, thus distinguishing Sri Lanka from rival countries with lower labor standards. While leading to some positive outcomes, most improvements appear to have been designed to make investors happy and not with the overall wellbeing of workers in mind (Ruwanpura, 2014; Hewamanne, 2017). Improvements pertaining to health and safety were mostly implemented in large FTZ factories, while the smaller factories that they subcontracted to remained under the radar.

In 2015 the UK government passed the Modern Slavery Act, which was designed to eradicate forced labor and to stop British companies from profiting due to forced labor. Article 54 of the act requires British companies to clean up their supply chains, locally and internationally. This made many British companies pay attention to working conditions in global factories and require local managers to clean up their work force of any slave labor. Hewamanne (2020b) argues that this requirement, rather than improving worker welfare, ended up being another surveillance regime. All these new developments make the dynamics within global production sites in Sri Lanka different from what existed during 2000-2006.

Additionally, Sri Lanka's cultural sensibilities and practices have seen rapid changes during the last decade due to increased usage of smart phones and cheaper internet rates. Many urban young people now own smart phones and are connected widely via social media sites to global cultural trends. The private TV channels have mirrored this by introducing copy-cat reality programs to find the next big star in singing, dancing, fashion and cooking, etc. These shows require contestants to go beyond traditional artistic skills, clothing, speech and movements and celebrate cultural fusion. Characters in tele dramas have also started portraying globally connected young people who espouse global values. All this has led to audiences of different generations grudgingly accepting some changes at varying levels.

While only a handful of FTZ workers owned mobile phones in 2005, by 2017 almost every worker owned at least a flip phone. Smart phone use is still not prevalent among FTZ workers and

⁴ Generalized Scheme of Preference + is a European commission special incentive arrangement for selected developing countries that ensures the reduction or removal of tariffs when importing goods to European countries. These privileges were stopped in 2010 in reaction to the weak human rights record of the then government but was reinstated in 2017 after the new government elected in 2015 worked toward improving good governance practices.

those with such phones use limited data plans due to the cost. In any case, knowledge of global values acquired via visual media does not seem to affect deeply held cultural values regarding certain gender norms, and this is especially so with regard to sexual and behavioral norms concerning reproduction. The following section discusses how existing norms shape the reproductive scenario among global factory workers.

Over 10 years since the 2006 article: Abortions in Crisis Moments

In 2017 NGO officials and neighbors readily agreed that they do not see or hear about emotional excesses associated with unwanted pregnancies (wailing, attempted suicides, etc.) as they did around 10-15 years ago (Hewamanne 2010). "Today's women are lot wiser. They know how to protect themselves and to discreetly take care of things if a pregnancy happens," one boarding house owner told me. An NGO staff member attributed this seeming decrease in unwanted pregnancies to long years of NGO workshops and FPASL leaflets harping on the need for safe sex. The chief nursing officer in charge of women's health at the Katunayake MHO credited it to support services provided by government and private medical practitioners. However, FPASL still regarded FTZ workers as a special population that needed targeted education and services, and several NGO staff members agreed with that assessment.

Sri Lanka's statistics on abortion have always been conservative estimates as abortion was illegal and women went to road-side abortion clinics which did not keep records.⁵ The then Minister of Health Dr. Ranjith Attapattu said that in 1984 in Colombo alone over 500 abortions were performed daily, and also added that this figure is "only the tip of the iceberg" (NIH 1984). Abeyasinghe (2009) estimated that for every 1,000 children born, another 740 had been aborted. The same kind of speculative estimates were made about the FTZ area adding to the general stigma against FTZ workers. The scenario has not changed much by 2018, when Dr. Lanerolle, Consultant Gynecologist at the Castle Street Women's Hospital, disclosed in a press conference that as many as one thousand abortions were taking place in Sri Lanka every day. Clearly abortion continues to be a crucial way that women deal with reproductive crises island wide.

In my 2015 survey 45% of respondents acknowledged to engaging or ever having engaged in sexual relations. Only 30% of the ones who were sexually active noted that they were willing participants of sex. However, only 8% checked that they were forced into sex. The others left the space blank or checked the 'not sure' box without explanations. This is, in fact, an ambivalence borne out of the above noted pressure to perform the good girl image, so that women resist even when they are willing, leading to difficulty in clearly recognizing their own intentions. During interviews only 4 out of the 15 women said they have had sexual relations, and all claimed that they engaged in sex (at least in the first instance) only reluctantly. All 15 women claimed to have much knowledge of contraceptives and said they knew how to obtain the pill and condoms. They were less knowledgeable about injectables and IUDs and only could speculate about where to access such services.

They were all aware of road-side abortion clinics in the area and claimed that they will know where to go if the need arises. All agreed that abortion should be legalized when associated with rape, incest and deformity. Only 5 out of 15 said that abortion should be openly accessible

⁵ According to Sri Lanka's penal code, an abortion can only be performed to save the life of the woman (Section 303). An abortion carried out for any other reason would result in imprisonment or fine or both for the woman and the person who carried out the abortion. A proposed amendment easing these restrictions had to be shelved in 2015 due to protests from different groups, especially the Catholic leaders.

for anyone. This is because they struggled with the differing ideological forces in their orbits—religious beliefs, cultural constraints on pre-marital sex, and newly formed ideas about personal freedoms. The surveyed women provided somewhat similar numbers with 32% of them either leaving the box about open access to abortion blank or responding in the negative. The others noted yes but only 15% provided reasons and that too were brief and mostly unclear.

Both the surveyed women and the interviewees agreed that women still go to road-side clinics to get abortions whilst knowing perfectly well that their services are substandard. 90% of the surveyed women noted that the affordable low prices as the main reason why women seek help at these clinics. Interviewees agreed, and many also talked at length about their low salaries and the cascading effects such economic disempowerment has on their social empowerment, including the ability to negotiate their reproductive choices with their partners. Adding to her comments on economic and social disempowerment, Malka said “I am angry at one level with these clinics for using unsanitary methods; but on the other hand, I cannot tell you how many women in this area have salvaged their reputations because these clinics exist.” However, she still hesitated in saying that abortions should be a regular service provided at government hospitals. “I don’t think that is practical, or a good thing. There are good contraceptives. It’s better to lower their prices than to spend public funds on providing abortions,” she said. However, she (and most other interviewees) still held that just having cheap and easily accessible contraceptives will not fully answer the reproductive problems of FTZ workers. They all noted how women are supposed to act as ‘sheltered good girls who have no knowledge of sex or contraceptives’ at the beginning of a relationship and how they find it hard to negotiate contraceptive usage with their partners even after the first sexual encounter. They agreed that many women in relationships use the pill but noted that with men reluctant to use condoms any mistake women make (such as forgetting to take the pill) results in pregnancies. In addition, they discussed how pregnancies took place when relatives, factory managers, and military and police officers forced women into sex. All the interviewees agreed that in such cases women have no other option but to get an abortion at one of the area clinics. They also thought it would be good if the government or NGOs provided services in all such crisis moments as women’s low wages only allowed them to seek abortions at road-side clinics.⁶

Morning-after Pill- Emergency Contraceptives to the Rescue

All FTZ workers that I discussed reproductive health matters with regularly mentioned the ‘morning-after’ pill (Postinor (levonorgestrel)).⁷ NGO staff and neighbors also mentioned the prevalence of this pill as an over-the-counter option and its role in preventing unwanted pregnancy. While workers for the most part talked about this emergency contraceptive option as a godsend for their particular needs, both the NGO officers and neighbors seemed conflicted about it. While they realized it was useful in cases of rape and unplanned sexual encounters, some felt the easy availability of emergency contraceptives would encourage irresponsible behavior. According to one NGO staff member, some women are “so frivolous and lazy” that they do not want to take the pill while their boyfriends are away. One worker, according to her, had asked whether there were

⁶ Unfortunately, care providers in Sri Lanka are also influenced by dominant cultural norms, and thus most do not approve of providing contraceptives to unmarried women (Hewage 1999) and are divided regarding abortion due to religious or moral reasons (Sirisena 1996; Pethiyagoda 2018).

⁷ While workers use the English term for the morning after pill, the pill works best within 12 hours after unprotected sex occurs.

pills she could take just before having sex as taking the pill every day was a chore. Echoing some of the concerns of NOG staff and workers themselves, an elderly boarding house owner said “morning-after pill is like providing ladders for jumping monkeys”—in other words more encouragement for women to engage in premarital sex. One neighbor thought emergency contraceptive takes away the one negotiating tool that women have of discouraging their boyfriends from manipulating them into having sex.

Yet, workers’ praise for the morning-after pill was based on particular reproductive health difficulties they faced. Geetha, one of the interviewees, identified the morning-after pill as the “only good thing that happened for us since the beginning of FTZ work.” She elaborated by saying that thanks to the morning-after pill she now does not have to argue with her boyfriend over his unwillingness to use a condom nor fear anyone finding out she was taking contraceptives. Geetha explained how difficult it was to take the pill and still manage her reputation in a crowded boarding room:

No one at my boarding house knows that we are having sex. I am an unmarried woman and we are not supposed to have sex, so taking the pill in the open is like advertising my sex life in a newspaper. I took the pill for about a year, and it was terrible. I had to keep the pills under lock and key and take it so secretly. When my pill cards and the boxes were empty, I had to smuggle them out to a factory bin rather than discarding them at the open rubbish pit of the boarding house. Really, do I have to suffer that much to have sex every two months or so?

The difficulties associated with taking the pill in a crowded boarding house while pretending to be “good girls” added to such women’s already difficult lives. As Geetha’s words evidenced, in spite of the concerns of mostly middle-class NGO officers⁸ and neighbors, the FTZ workers found the morning-after pill an empowering tool in negotiating reproductive agency. Neomi, although she claimed to not ever had sex, agreed by noting that she understands how difficult it is to remember to take a pill every night and the need to do this in complete secrecy. “I was skeptical at first when I heard that there is a pill such as this; but if it is working, why not use it. Seems like a perfect solution if your boyfriend forces you to have sex or you get raped or in case you forgot to use any contraceptives,” she added. Survey responses were nearly unanimous that the morning-after pill was a necessity in the FTZ area and that it should be made even more easily accessible.

When discussing how the morning-after pill had made it easier to deal with boyfriends unwilling to use condoms, the few women who admitted to having sex framed the conversation within a language of empowerment and agency. They said easy accessibility of the morning-after pill, which one can currently purchase for Rs. 150 (under \$1) from any area pharmacy, allowed them to feel that they were in control. Over the years, women workers had noted how pharmacists made them feel like whores for trying to buy condoms (Hewamanne 2016). No one said this happened when trying to buy the morning-after pill, although I have a difficult time believing that to be the case. That noted, Sheila, I believe, spoke for the FTZ women engaged in sex when she said the morning-after pill is “the best friend and savior of FTZ workers.”

⁸ In 2006 too I found that state and NGO personnel (who were middle class) were deeply conflicted over their role in educating unmarried women on reproductive technology, and these conflicts were inadvertently conveyed to workers during educational workshops (Hewamanne 2008). While less the case in 2018, the discomfort continued to be evident notwithstanding discourses on personal freedom, women’s choice and reproductive rights and agency.

Conclusion

Both the 2006 data and data from 2015 and 2017 show that women workers continue to use the services provided by road-side abortion clinics. In addition, in 2015-2017 they also routinely use the morning-after pill to prevent conception and consider both practices viable forms of contraceptives (to prevent conception or birth). Both sets of research data also demonstrate that women have much knowledge of reproductive technology and that they continue to find it difficult to negotiate contraceptive use within relationships.

While it is obviously a positive that the cheap and fairly effective morning-after pill is easily available, it is problematic how FTZ workers consider an emergency contraceptive the best method that allows them full agency in managing reproductive choices. Both forms—abortion and morning after pill—are chosen due to the difficulties women encounter when negotiating with partners, and that highlights the need to focus not only on knowledge acquisition but also on the nexus of power shaping the reproductive experiences of women who have become trapped within differing ideologies in a rapidly changing society.

Earlier studies on links between power relations and reproductive health focused on how cultural perceptions of virginity, sexual passivity and other sexual mores can affect reproductive decision-making (Tilahun et al, 2012; Dalessandro et al, 2019). The deeply internalized sexual mores and ideals of femininity in Sinhala society are incompatible with migrant FTZ workers' lifestyles and new knowledges that they become privy to within and around the FTZs. Yet, the ambivalences, silences and expectations created by cultural discourses still shape romances and sexual relationships in the FTZ area, leading to unmet contraceptive needs and the preference for emergency birth prevention methods.

The effects of gendered power imbalances and socio-economic marginalization on local reproductive practices have been well documented (Mason and Smith, 2000; Blanc, 2001; Kraft et al, 2014). Such studies suggest that inequality within relationships hamper discussion of reproductive choices. They also suggest that education and women's socio-economic status can improve communication between couples and, consequently, improve decisions regarding reproductive health (Singh et al, 2001; Canning and Schultz, 2012). In fact, research in Sri Lanka show that while ethical production norms improved health and safety standards within FTZ factories; many lag behind in paying a living wage. Wages have vastly improved since 2000, when the basic monthly salary was Rs. 2,500 (US\$25). Today an average FTZ worker's take-home salary is approximately Rs. 25,000 (US\$153). However, massive inflation and the devaluation of currency rates during the intervening years have diminished the buying power of this six-fold increase. For instance, in 2000 the FTZ boarding house fee was Rs. 900, but it was Rs. 3,500 in 2018. Ultimately, such low salaries do not enable workers to have much say when negotiating reproductive decisions within relationships. Without substantially increased wages and changes in workers' living and social conditions, which will elevate women's reputation in the eyes of their boyfriends, women will continue to experience inequalities and powerlessness within relationships. But since global garment production was initiated to cut costs by using cheap "third world" female labor, such wage increases are unlikely to happen. Yet, better wages are a necessary condition for any meaningful improvement in workers' reproductive health, safety, and overall well-being.

Most stakeholders associated with workers' reproductive scenario sought solutions for workers without making the women workers an integral part of the discourse. This research demonstrates that workers were neither ignorant about reproductive technology nor naïve about the difficulties in exercising their reproductive rights. If they consider the morning-after pill a

godsend and illegal, unsafe abortion a fall back option, that is, in fact, a critique of the above-mentioned actors and agencies who represent and advocate for FTZ workers using their own particular agendas. Thus, this paper highlights the need for an approach, which treats all actors as equal partners and seeks via democratic dialogue to learn from each other.

References

- Abeyasinghe, N. L. (2009). Awareness and views of the law on termination of pregnancy and reasons for resorting to an abortion among a group of women attending a clinic in Colombo, Sri Lanka. *Journal of Forensic and Legal Medicine*, 16: 134–137.
- Agampodi, S., Agampodi, T., and U. Piyaseeli. (2008). Adolescents perception of reproductive health care services in Sri Lanka. *BMC Health Service Research*, 8:98. doi: 10.1186/1472-6963-8-98.
- Ali, K. (2002). *Planning the Family in Egypt: New Bodies, New Selves*, Austin: University of Texas Press.
- Arambepola C., Rajapaksa, L., and C. Galwaduge. (2014). Usual hospital care versus post-abortion care for women with unsafe abortion: A case control study from Sri Lanka. *BMC Health services Research*, 14: 470.
- Blanc, A. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. *Studies in FamilyPlanning*, 32 (3): 189–213.
- Bujawansa, B. (2002). An analysis of fifty cases of unintended pregnancy. *Sri Lanka Family Physician*, 24 (1): 37–9.
- Canning, D., and P. Schultz. (2012). The economic consequences of reproductive health and family planning. *LANCET (Science Direct)*, 380 (9837): 165-171.
- Chandra-Mouli, V., Plesons, M., Hadi,S. Baig,Q. and I. Lang (2018). Building support for adolescent sexuality and reproductive health education and responding to resistance in conservative contexts: Cases from Pakistan. *Global Health Sci Practice*, 6 (1):128-136.
- Daily Mirror. (2018). Shocking, shameful; About 1,000 abortions daily in Sri Lanka. 14 July 2018 12:03 am. <http://www.dailymirror.lk/article/Shocking-shameful-about-abortions-daily-in-Sri-Lanka-152709.html>
- Dalessandro, C., James-Hawkins, L. and C. Sennott. (2019). Strategic Silence: College Men and Hegemonic Masculinity in Contraceptive Decision Making. *Gender and Society*, DOI: <https://doi.org/10.1177/0891243219850061>
- Dansereau, E., Schafer, A., Hernandez, B., Nelson, J., Palmisano, E., Zertuche, D., Woldeab, A., Zuniga, M., Iriarte, E., Mokdad, A. and C. Bcheraouli. (2017). Perceptions of and barriers to family planning services in the poorest regions of Chiapas, Mexico: A qualitative study of men, women, and adolescents. *Reproductive Health*, 14: 129.
- Darroch J.E. and Singh S. (2012). Trends in contraceptive news and use in developing countries in 2003, 2008, and 2012: An analysis of national surveys. *Lancet*, 2013:381 (9879):1756-62.
- DeGraff, D. and K.A.P. Siddhisena. (2015). Unmet need for family planning in Sri Lanka: Low enough or still an issue? *International Perspectives on Sexual and Reproductive Health*: 200-209.
- Denno, D.M., Hoopes, A.J. and V. Chandra-Mouli. (2015). Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *Journal of Adolescent Health*, 56: S22-41.
- Ginsburg, F., and R. Rapp. (1991). The politics of reproduction. *Annual Review of Anthropology*, 20: 311–43.
- Ginsburg, F., and R. Rapp (eds). (1995). *Conceiving the new world order: The global politics of reproduction*. Berkeley, CA: University of California Press.

- Hettiarachchi, T., and S. Schensul. (2001). The risks of pregnancy and the consequences among young unmarried women working in a Free Trade Zone in Sri Lanka. *Asia-Pacific Population Journal*, 16 (2): 125–140.
- Hewage, P. (1999). Induced abortion in Sri Lanka: Opinions of reproductive health care providers, in A. Mundigo and C. Indriso (eds), *Abortion in the developing world*, New Delhi: Vistaar.
- Harnois, C., and Hewamanne, S. (2020). Categorical variables without categorical thinking? A relational reading of the Sri Lankan Demographic and Health Survey. *Gender Issues* 37(2).
- Hewamanne, S. (2003). Performing dis-respectability: New tastes, cultural practices and identity performances by Sri Lanka's Free Trade Zone garment factory workers. *Cultural Dynamics*, 15 (1):71–101.
- Hewamanne, S. (2008). *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*. Philadelphia: University of Pennsylvania Press.
- Hewamanne, S. (2010). 2010. Suicide narratives and in-Between identities among Sri Lanka's global factory workers. *Ethnology* 49 (1): 1-22.
- Hewamanne, S. (2012). Negotiating sexual meanings: Global discourses, local practices and Free Trade Zone workers on city streets. *Ethnography*, 13(3):352–74.
- Hewamanne, S. (2016). *Sri Lanka's Global Factory Workers: (Un)Disciplined Desires and Sexual Struggles in a Post-Colonial Society*. London: Routledge.
- Hewamanne, S. (2017). Health and safety for ten hours plus: Why CSR policies are not successful as envisioned. *Unmaking the Global Sweatshop: Health and Safety of the World's Garment Workers*, eds., Geert De Neve and Rebecca Prentice. Philadelphia: University of Pennsylvania Press.
- Hewamanne, S. (2019). From global workers to local entrepreneurs: Former global factory workers in rural Sri Lanka. *Third World Quarterly* 41 (3).
- Hewamanne, S. (2020a). *Re-Stitching Identities in Rural Sri Lanka: Neoliberalism, Gender and Politics of Contentment*. Philadelphia: University of Pennsylvania Press.
- Hewamanne, S. (2020b). Surveillance by another name: The Modern Slavery Act, global factory workers, and part-time sex work in Sri Lanka. *Signs: Journal of Women in Culture and Society* 45(3): 653-678.
- Jordal, M., Wijewardena, K., Öhman, A., Essén, B., and P. Olsson. (2014). Negotiating respectability: Migrant women workers' perceptions of relationships and sexuality in Free Trade Zones in Sri Lanka. *Health care for women international*, 35 (6): 658-676.
- Jordal, M., Wijewardena, K., Öhman, A., Essén, B. and P. Olsson. (2015). Disrespectful men, disrespected women: Men's perceptions on heterosexual relationships and premarital sex in a Sri Lankan Free Trade Zone: A qualitative interview study. *BMC International Health and Human Rights*, 15:3. <https://doi.org/10.1186/s12914-015-0040-4>
- Kabagenyi, A., Reid, A., Notzi J., and L. Atuyambe. (2016). Socio-cultural inhibitors to use of modern contraceptive techniques in rural Uganda: A qualitative study. *Pan African Medical Journal*, 25:78. doi: 10.11604/pamj.2016.25.78.6613
- Kraft, J., Wilkins, K., Morales, G., Widyono M. and S. Middlestadt. (2014). An evidence review of gender-integrated interventions in reproductive and maternal-child health. *Journal of health communication*: 122-141. <https://doi.org/10.1080/10810730.2014.918216>
- Mason, K. (1994). HIV transmission and the balance of power between men and women: A global view. *Health Transition Review*, 4: 217–40.

- Mason, K., and H. Smith. (2000). 'Husbands' versus wives' fertility goals and the use of contraception: The influence of gender context in five Asian countries. *Demography*, 37 (3): 299–311.
- Mullings, L., and A. Wali. (2001). *Stress and Resilience: The Social Context of Reproduction in Central Harlem*. NY: Plenum Publishers.
- National Institute of Health. (1984). Concern rises over abortion rate in Sri Lanka. (pub.med.gov). July 8(3):11.
- Obeyesekere, G. (1984). *The cult of the goddess Pattini*, Chicago: University of Chicago Press.
- Olsson, P. and K. Wijewardena. (2010). Unmarried women's decisions on pregnancy termination: Qualitative interviews in Colombo, Sri Lanka. *Sexual and Reproductive Health*, 1: 135-141.
- Pethiyagoda, R. (2018). Abortion: The agony of a nation. *Daily Financial Times*, Thursday, 18 January 2018 00:00. <http://www.ft.lk/columns/Abortion--The-agony-of-a-nation/4-647452>
- Sheikh, S. and T. Loney. (2018). Is educating girls the best investment for South Asia? A systematic review of the literature. *Frontiers in Public Health*, 13 July 2018 |<https://doi.org/10.3389/fpubh.2018.00172>
- Singh, S., Darroch, J. and J. Frost. (2001). Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries. *Family Planning Perspectives*, 33 (66): 251–8 and 289.
- Singh, S., Darroch L., and L. Ashford. (2014). Adding it up: The costs and benefits of investing in sexual and reproductive health. NY: Guttmacher Institute.
- Sirisena, J. (1996). Gynecologists' Opinion on Induced Abortion. *Proceedings of the Kandy Society of Medicine Annual Sessions*, 18.
- Tilahun, M., Mengistie, B., Egata, G., and A. Reda. (2012). Health workers' attitudes toward sexual and reproductive health services for unmarried adolescents in Ethiopia. *Reproductive Health*, 9:19. <https://doi.org/10.1186/1742-4755-9-19>
- Wickramagamage, C. (2000). Her body, her, right? Interrogating th discourse on abortion rights in Sri Lanka. Paper presented at the Seventh National Convention on Women's Studies, Center for Women's Studies, Sri Lanka, 23–26 March.