Trading futures: Sadaqah, social enterprise, and the polytemporalities of development gifts

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Trading Futures: *Sadaqah*, Social Enterprise, and the Polytemporalities of Development

Gifts

Abstract
In this article, we explore what happens when idea(l)s of Islamic charity (*sadaqah*) and social enterprise converge within a low-cost public health clinic in Colombo, Sri Lanka. For both the clinic’s wealthy sponsors and the urban poor who used it, interpreting the intervention as a pious expression of care towards the poor or a for-profit humanitarian venture entailed trading different futures the clinic represented. How the ambiguous temporalities of gifts and commodities anticipated by benefactors and beneficiaries played out challenges, in turn, anthropological assumptions concerning the marketizing effects of neoliberal development interventions. Our ethnography revealed a hesitancy among the clinic’s sponsors, managers, and users to endow the intervention with a final interpretation, leaving open its potential as a vehicle for promoting the privatisation of healthcare.

Key words
Charity; gift; Islam, social enterprise, Sri Lanka; temporality

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Trading Futures: Islamic Charity, Social Enterprise, and the Polytemporalities of Development Gifts

Introduction

Tucked away in the backstreets of Slave Island, a bustling but low-income Malay quarter in the Sri Lankan capital Colombo, an unassuming medical centre provides free health checks and cut-price prescriptions for local residents. CommClinic, a non-profit initiative of a wealthy Muslim family originating in a gift of *sadaqah* (voluntary charity) delivered via the corporate social responsibility (CSR) team of the company they own, was one of three options for medical treatment available in the area. The other two, a tax-funded municipal health centre and a doctor’s private surgery, had reportedly struggled to attract users since the appearance of CommClinic, some three years earlier. Insofar as CommClinic was able to successfully attract both low- and middle-income patients and change health seeking choices in Slave Island, it had succeeded in its stated mission of “bridging the gap” between public and private health sectors in Sri Lanka. CommClinic proved attractive to patients, ostensibly at least, because it combined the presumed benefits of public and private health provision (respectively, affordability and customer focus) while solving some of their problems (specifically, waiting times and a lack of trust) (c.f. Russell & Gilson, 2006; Russell, 2005).

Our opening portrait of health market “diversification” in Colombo that CommClinic represented obscured a complicated set of moves through which actors launched, delivered, and used the service. We referred to multiple kinds of economic, social, and political language and practice that imbued the service – from Islamic charity through CSR to the needs and

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2 Rather the seeking to define Muslims’ almsgiving with reference to Islamic canon, we focus on lived ideas and practices as we found them during fieldwork. In this article, we mention *zakat*, which is central to Islamic
aspirations that directed patient choices between private and public services. Underpinning those models and modalities of healthcare was a shifting commitment on the part of the programme’s benefactors to replacing beneficiaries’ exposure to financial indebtedness caused by high private healthcare costs, with a moral obligation to taking on responsibility for their own economic wellbeing. As CommClinic unfolded, this ambition proved more complicated than it originally appeared to be, in terms of how benefactors, managers, and users actually made sense of the programme’s stated charitable origins, compared with what it became at point of delivery – a fee-based service. The contestations that arose around aspirations for converting financial debts into moral obligations via religious gifts and commercial relationships reveals some of the practical and conceptual conflicts that arise when the different temporalities that adhere to gifts and commodities collide within a single organisational setting.

We approach these issues by asking what CommClinic meant for the different actors involved in its design, delivery, and use. Social enterprises can include charities running moneymaking ventures to provide them with an income stream, to regular businesses that direct profits to humanitarian and development activities. The concept of social enterprise is ambiguous, with legal, financial, and organisational form varying between historical and social contexts and regulatory regimes (Wolcott 2009). They resemble what de Laet and Mol (2000, 225) have called “fluid objects” – unbounded organisational forms that are “adaptable, flexible and responsive.” Within the context of global health and development where intervention models routinely “travel” (Petryna 2009), fluidity has helped to make social enterprise compatible with otherwise incompatible models of healthcare delivery – for example, by simultaneously embodying charitable and market models.

orthopraxis, and sadaqah, a routine and daily expression. Zakat, a form of worship, is a religious obligation performed by giving a percentage of one’s wealth to specific categories of (Muslim) deserving recipients. It is distinguished from voluntary almsgiving, sadaqah, which is not regulated by normative rules and can be given by anyone to Muslims and non-Muslims alike (Benthall 1999; Bonner, Ener, and Singer 2003; Singer 2006).
Like other “bottom of the pyramid” (Prahalad 2005) interventions, social enterprises like CommClinic are rooted in a belief that only once the poor take responsibility for their own lives and provided mechanisms for doing so can they escape the causes of poverty. A growing critical literature has shown how such approaches can also drive cuts to public services and engender new forms of economic, social, and health marginalisation. Taking the shape of what Elyachar calls “empowerment debt” (2005) and Roy defines as “poverty capital” (2010), the poor are encouraged to develop an ethic of self-care attuned to neoliberal logic (Elyachar 2012; Dolan, Johnstone-Louis, and Scott 2012; Cross and Street 2009; Dolan and Johnstone-Louis 2011; Watanabe 2015; Rajak 2010; Lazzarato 2012). By “helping the poor to help themselves” through the transfer of an entrepreneurial spirit through which the poor can adopt an attitude of self-responsibility for their future wellbeing, the entrepreneurial spirit of wealthy benefactors travels to beneficiaries (Atia 2013; Muehlebach 2007; Allahyari 2000; Trundle 2014; Osella 2017; Tittensor 2014).

Whilst anthropologists have revealed how such motivations transform ostensibly altruistic or pious intentions into a more complicated and interested act, they have rarely discussed the organisational mechanisms of subjectivation itself. Recipients’ own experiences have also only been attended to sparingly (Copeman 2011; Osella and Widger 2018; Gregory 1992). The metaphors that anthropologists have used to describe the “social life” (Appadurai 1986; Stirrat and Henkel 1997) of gifts that “travel” (Petryna 2009; Ong and Collier 2005) from benefactors to beneficiaries reveals an underpinning assumption that programmes like CommClinic operate in broadly linear terms – with benefactors’ largely unambiguous foundational values transferring more or less unfettered to beneficiaries. There has been surprisingly little attention paid to the question of whether benefactors hold true to their own ethical vision, or whether beneficiaries respond positively towards, let alone care for, the subjective transformations of “responsibilisation” that such interventions apparently seek
(Trnka and Trundle 2014). In what follows, we point to the struggles that benefactors experience in actually delivering what they set out to achieve in terms of the ethical transformation of the poor-Other, and the circulation or counter-flow of meaning that emerges from beneficiaries’ acceptance, translation, redeployment, or refusal of benefactors’ aspirations.

The article draws from ethnographic research conducted over a period of 18 months, from February 2012 to July 2013. First, we interviewed two of CommClinic’s original benefactors, LankaComm’s current and past CEOs, Bilal and Esmail, at company headquarters. Second, we held four separate meetings with LankaComm’s two-person CSR team, Samuel and Nimis, over a period of several months as we conducted longer-term fieldwork in CommClinic settings in Slave Island and Grandpass. Third, we conducted a household survey and collected case study examples of CommClinic use among a sample of 66 local residents in both communities. The article begins with a brief introduction to the Sri Lankan healthcare market, and the significance of CommClinic within processes of service provider diversification and privatisation that have been taking place over the past few decades. The next three sections follow the design, delivery, and use of CommClinic from the perspectives of LankaComm’s CEO and CSR team, and local people in Slave Island and Grand Pass. By way of conclusion, we reflect on how the fluid meanings of CommClinic and paying closer attention to beneficiaries’ responses challenges anthropological assumptions concerning the subjective transformations instigated by philanthropic interventions.

**The Sri Lankan healthcare “market”**

The origins of the Sri Lankan healthcare system lie in philanthropic investment in hospitals and other infrastructure during the nineteenth century (Hewa 2012; Jones 2009). Following independence from British rule in 1948, the post-colonial government launched a “Free Health”
policy in 1951 that saw the nationalisation of charitable and private hospitals and establishment of free-at-point-of-use curative and preventative services funded through general taxation (Alailima 1995; Silva 2009). The outcome of sustained public investment across the second half of the twentieth century has been the development of an extremely high quality healthcare system, especially in relation to preventative services, and excellent performance on population health indicators (Gupta et al. 2013; Samaratunge and Nyland 2006).

At the ideological level, free public healthcare remains a central commitment among all the major political parties – even while pressure from international donors including the IMF led to gradual privatisation from the late 1970s (Kumar 2019). Today, public healthcare comprises just 50 percent of outpatient care, although still accounts for 90 percent of inpatient care. While private inpatient services remain beyond the reach of all but the wealthy middle and upper classes, outpatient services (clinics and dispensaries) offering routine health tests, consultations, and prescriptions have burgeoned and are, in principle at least, accessible for all but the very poorest. Thus, around half (54 percent) of health spending in Sri Lanka comes from private sources, including 85 percent paid out-of-pocket, 5–8 percent paid via employer benefits, 5 percent paid via health insurance, and just 2–3% covered by the non-profit sector (Kumar 2019).

Although Sri Lanka has so far not experienced significant levels of healthcare “diversification” seen in other countries, the gradual expansion of a healthcare market has worked to challenge public provision on both practical and ideological grounds. Publicly-funded curative services have suffered from chronic underinvestment leading to staff and resource shortages, which has in turn led to a growing political acceptance and appetite for the development of a market model incorporating private and public-private providers (Kumar 2019). The majority of medical practitioners employed in the private sector remain public sector employees, and divide their day between both sectors – often working in public settings...
in the morning and private settings in the evening. A much-repeated complaint among the public in Sri Lanka is that state services suffer due to the time constraints this places on medical staff wishing to “get away” to their (lucrative) private clinics.

The relatively high price of private healthcare poses a significant risk to the financial security of low-income households. Russell and Gilson (2006) showed that for those on the lowest incomes in Colombo, the existence of free healthcare was an important social protection measure as even the smallest health expenditure could tip a household into poverty and debt. A study conducted by the Catholic development NGO Caritas (n.d.) provided an indication of the levels of debt in Colombo’s low-income communities, much of which was created by the preference for private healthcare. The researchers found that for the urban poor, the “escalating costs of living and the fact that their meagre savings could not meet the expenses related to sudden shocks such as illness…in the family” was a cause of indebtedness (ibid: 38). Similarly, The Women’s Bank of Sri Lanka\(^3\) has argued that healthcare costs are a significant cause of household debt.

Given the popularity of free healthcare in Sri Lanka among the public and its continued importance in poverty reduction and social protection, the growing market for private healthcare options is perhaps surprising. Russell and Gilson (Russell & Gilson, 2006; Russell, 2005) have suggested that while public services in Colombo tended to enjoy greater levels of public trust overall (for example, they were seen by respondents to their research as subject to greater levels of accountability and oversight), private services were popular simply because patient waiting times were shorter. According to Russell and Gilson’s interlocutors, private services benefited from a narrative of *convenience*, which when it came to minor health complaints was valued as more important than *trust* by their research participants. As our own findings discussed below suggest, a confluence of subjective transformations linked with the

\(^3\) [http://www.gdrc.org/icm/inspire/womenbank.html](http://www.gdrc.org/icm/inspire/womenbank.html)
re-valuation of time and status found in narratives of *convenience* and *waiting* helps to explain the growing acceptance in Colombo of the idea that healthcare can be paid for, as well as being one of the central messages accompanying CommClinic branding.

It has been against this background of market diversification on the one side, and growing risks of health inequality on the other side, that recent philanthropic investments in health have played out. Our research in Colombo revealed very high levels of voluntary investment in health infrastructure, public health drives, community health camps, and patient sponsorship – amounting to what we term a *health philanthroscape* (Osella, Stirrat, and Widger 2015). Sri Lanka also boasts the highest levels of blood, organ, and whole body donation in the world, with the supply in corneas outstripping local demand to such a degree that the island exports tissues to countries around the world (Simpson 2017). For many Colomboites we spoke to, health represented a productive field for participation as both givers and receivers of gifts and donations, generating material and spiritual merits and blessings for the healthy wealthy and the deserving poorly – and for the poor whose gifts of small change and blood and tissue donations too offered pathways to social and spiritual satisfaction.

**The future uses of sadaqah**

It was thus into this health philanthroscape of economic and spiritual economies (Rudnyckyj 2010) that the owners of LankaComm, one of Sri Lanka’s biggest conglomerates, decided enter when they launched CommClinic. According to the company website, CommClinic was “inspired by the idea of providing free medical consultation and subsidised drugs to patients.” The aim was to appeal to “patients from lower income segments who are unable to afford the usually high-priced private healthcare system…by giving an affordable solution to the people without compromising on quality and efficiency of health services.” In 2013, it was company
policy that no prescription should cost more than Rs.200 (c. £1.00), whilst the average cost of a private prescription was Rs.800 (c. £4.00).

We met one of LankaComm’s founding members in his office at the company headquarters, a new three-storey building off Colombo’s central Galle Road. Bilal was a cordial and jovial man, peppering our conversation with jokes about himself and his Memon Muslim community. He was keen to stress that he was a very busy man. He had just returned from a business trip to Dubai, and we met was preparing to leave for Singapore and Hong Kong to “inaugurate two new companies of the LankaComm group.” “Our chat will be short,” Bilal told us, but we could then talk at length with two of his employees who managed LankaComm’s CSR programmes.

Bilal together with his four “cousin-brothers” (father’s brother’s sons) founded LankaComm PLC in the late 1970s with a modest capital of £1,500. After 35 years, LankaComm had developed into one of Sri Lanka’s most successful corporations, and although the cousin-brothers floated the company on the Colombo stock exchange in the 1990s, the founding family retained a controlling stake. Bilal was extremely proud of his business achievements, but it was not a rag-to-riches story. The family had its roots in Gujarat where they had run a thriving textile business. On the eve of Partition, escalating attacks on Muslims convinced Bilal’s grandfather to send his two sons to Colombo to set up business there, “just in case conditions worsened.” The rest of the family stayed put in Gujarat until after Independence, but left for Colombo after anti-Muslim violence that followed Gandhi’s assassination in January 1948. The original plan was to move eventually to South Africa, but “business was good in Colombo, so we stayed here,” Bilal told us. “We are Muslim Memons,” he said with a glistening smile, “business is in our blood!”

A successful entrepreneur, Bilal was keen to talk to us about his charitable endeavors as he was family history. He explained how the vast majority of what he gave took the form of
Zakat, the compulsory monetary alms that all Muslims of a certain financial worth must give, and sadaqah, a term that translates as “charity” and encompasses any form of spontaneous or planned assistance to others – be it in the form of cash, kind, or time. Bilal was keen to stress that the Islamic laws governing the value and destination of zakat and sadaqah aside, he gave both with equal commitment to ensuring that he supported only worthy causes for achieving maximum return. Bilal declined to tell us how much zakat he gave every year, because “it is a personal matter between God Almighty and me.” “Also,” he grinned, “if I tell you the amount, you will be able to work out my assets, and this is private too!”

However, Bilal did talk freely about the sadaqah (voluntary charity) he gave, much of which he still channeled collectively with his brothers via the company’s CSR team. Bilal explained they ran a number of different schemes to help “the poor, mainly Muslims,” including help to start a small business, to pay for marriage expenses and medical emergencies, and to provide interest free loans. They also gave money to the local Memon Association and two well-known Muslim charities, the Ceylon Baitulmal Fund (established in 1957 by a prominent Colombo Muslim politician; see Osella 2017) and Mercy Lanka (a social service organization funded by Al-Rahma International of Kuwait). Among those interventions was CommClinic, LankaComm’s jewel in the crown – the most ambitious and most expensive programme the brothers had supported.

For Esmail, LankaComm’s past CEO, CommClinic’s ethos was grounded in the Islamic commitment to assisting the poor and needy living in close proximity oneself. During an interview, he told us, “[Islam teaches] that if someone in your neighbourhood is starving it’s a sin on you to have proper meals, or fill yourself up.” It was for this reason that LankaComm opened the first CommClinic in Slave Island, a short walk from LankaComm’s headquarters off Galle Road. Esmail also stressed their involvement in the programme adhered to the ethic of disinterested giving associated with sadaqah, in that the brothers’ involvement in
CommClinic had never been highlighted, and neither had LankaComm’s backing of CommClinic featured as part of its branding. Repeating the well-worn phrase “the left hand should not know what the right hand is doing,” Esmail insisted that CommClinic was run independently from its benefactors’ personal or business interests – that the gifts that launched and sustained CommClinic during the first few years of its life were “pure.”

Nevertheless, how LankaComm then delivered the gift to recipients complicated these claims. The focus on healthcare itself emerged from what Esmail had described as a gap in the market for private services that was oriented to the needs of low-income people:

There is severe gap between the service providers – the government hospitals and the private hospitals – there’s a huge gap. The health sector is costly for private prescriptions….The government service is uncomfortable and not good…And the people who go to the government hospitals just can’t afford to pay for the services you get from the private hospitals, so we want to bridge that gap.

For Esmail, the gap that existed between public and private healthcare was not only one created by the variable standard and cost of service. It was also rooted in the challenge that it presented in terms of cultivating an ethic of appreciation and respect among the poor. Such uplift would emerge from the very fact of paying for a service. As Esmail told us:

People have just become used to getting medicines for free. When they are sick but don’t have money they don’t get help. It’s better if they pay something because then they value what they have and work harder to keep it.
Throughout our fieldwork in Colombo, we regularly encountered the belief that charity recipients failed to appreciate the help they were given unless required to “give something back” (Osella, Stirrat, and Widger 2015). This not only had the effect of encouraging dependency, despondency, and lack of self-esteem among the poor – it also signalled their inability to participate in “spiritual economies” (Rudnyckyj 2010) of gifting that provided a key means through which blessings and merits could be accrued (Haniffa 2017; Osella 2017) – a distinctive feature of the Sri Lankan health philanthroscape. For some organisations, including LankaComm, the social enterprise model that combined a fee-based approach with an ethos of “affordability” and “inclusion” (summed up in its motto of “bridging the gap”) provided a framework within which those marginalised from economies (spiritual and otherwise) could begin to participate by “think[ing] about debt, investment, and loss in statistical terms” (Appadurai 2013, 4). The solution that LankaComm came to, as Esmail explained it, was deceptively simple: “Two years back our chairman had an idea. The consultation will be free, medicines sold at cost price.”

To that end, Bilal and Esmail both revealed aspirations that CommClinic could become a leading example of “pro-poor” private healthcare in the developing world. In 2014, after just four years of being in business, CommClinic celebrated its 100,000th “customer.” Fees levied that same year exceeded operational costs, making the programme profitable for the first time. Recognising a market opportunity when he saw one, Esmail described how LankaComm was now seeking to consolidate its foothold in the healthcare sector. Their strategy would entail opening not only a dozen or so new CommClinic sites outside Colombo, but also a full inpatient hospital in Colombo. To achieve that goal, Esmail was also wary that they had to move quickly, because the risk of competition was rising:
What we feel is, if we get this concept going, we might find a lot of other people following suit...[A] lot of the corporate bodies might want to do this as one of their CSR projects. So we might set the trend.

Yet LankaComm’s vision to “bridge the gap” between public and private healthcare also transformed the nature of the relationship implied in the giving and receiving of *sadaqah* – a shift that played on the minds of Bilal and Esmail, who were both keen to stress they received no financial return from their donation. However, by charging a nominal fee, LankaComm had also proven that the CommClinic programme could sustain itself without further charitable intervention on the part of the founders. The originating gift of *sadaqah* was thus temporally sealed off from its point of delivery in a fee-based service, retaining its character as a “pure” development gift (Stirrat and Henkel 1997). And it was precisely for this reason that Bilal and Esmail could stress that although a business CommClinic offered an excellent vehicle for discharging their obligations to God, by “helping the poor to help themselves.” It was through the introduction of a fee-paying model of healthcare that Colombo’s urban poor were to be uplifted, simply by becoming more familiar with the concept of “paying their way.”

**The risks of commodification and the protective force of charity**

Operational responsibility for the CommClinic programme lay with LankaComm’s small CSR team, consisting of a director, deputy director, and a couple of administrative staff. Samuel, the CSR director, was keen to share the contributions of his own vision and efforts in the success of CommClinic. When we met, Samuel had just finished reading a book on social entrepreneurship published by Richard Branson, the founder of the Virgin business empire. Samuel explained that Branson had recently launched a website showcasing innovative social enterprise models and he was working towards a submission for CommClinic. The challenge
that Samuel faced in doing so involved a struggle to reconcile the two sides of CommClinic that Bilal and Esmail had also told us about – on the one hand, the programme’s origins in a gift of *sadaqah*; on the other hand, its adoption of a business model. Perhaps because he was a Christian, or perhaps because the gift did not originate from him, but for Samuel the difficulty lay less in the possible tensions of marrying religious orthopraxy with market rationality, than it did in the different subject positions that CommClinic “users” or “customers” would subsequently occupy in service settings.

The major advantage of a social enterprise model, as Samuel saw it, was the avoidance of what he called the “charity problem.” In terms echoing Esmail’s, Samuel explained that although “[medicines] are free from the government, the problem is that our people don’t respect things if they are given for free, so we charge a small amount.” By levying a fee for CommClinic’s services, Samuel wanted to foster what he called an ethic of “self-respect” among the poor. However, in this Samuel also recognised a potential risk. By requesting payment, CommClinic also acquired new responsibilities towards its patients, whose status transformed from recipients to customers. With such transformation came new expectations on the part of “customers” for a service akin to that provided in the private sector. Meanwhile, charges of inefficacy or medical negligence that could lead to negative media reports or claims for compensation. Ironically, Samuel argued that as a *charitable service* CommClinic had the right to refuse treatment to anybody whose ailments exceed the limited capacity of the clinic. As Samuel explained, “There is a risk of litigation and as a CSR project we want to avoid that. We stay away from serious accidents. We’ve told the doctors not to admit any patients who are serious but to always send them to hospital. We have to protect our brand.” Samuel’s solution was to reemphasise LankaComm’s charitable underpinnings, which he regarded as providing the best defence against the predicaments of a market relationship implied by social enterprise. In so doing, CommClinic was able to cherry-pick the least serious medical cases, leaving to
public hospitals those which were deemed too costly and time-consuming, or altogether intractable – a move that transferred risk from CommClinic back into the public sector.

Samuel’s approach to risk mitigation also meant resisting a firm categorisation of what CommClinic was supposed to be – a charity or a social enterprise. If the future that CommClinic represented was in the business of low-cost private healthcare, then the LankaComm needed to accept the liabilities and risks that came with it. However, if LankaComm wanted to reduce its exposure to risks, then CommClinic was compelled to reoccupy the ground of charity. Just as Bilal and Esmail had left the future of CommClinic open to determination as means of protecting the purity of their originary gift of *sadaqah*, Samuel avoided a firm designation for CommClinic as a means of protecting the CommClinic and LankaComm brands from damage.

**Choosing futures that fit: On using CommClinic or not**

Thus far, we have described the kinds of futures that CommClinic’s benefactors and managers imagined they could or should offer the poor, and how such temporal commitments shaped the ways they imagined CommClinic might deliver healthcare. We now move to consider how those who lived near CommClinic branches in two inner city neighbourhoods in Colombo responded to those visions. At Slave Island, the clinic was located opposite a government housing scheme, to the rear of which were illegal “encroachments” that over the decades had developed from slum dwellings into solid, well-maintained homes. At Grandpass, the clinic was located in a maze of multi-storey encroachments of better quality than those found at Slave Island. A range of public and private healthcare facilities, within walking distance or a short bus or trishaw ride away, served both communities. At Slave Island, a municipal dispensary, open between normal working hours (8am and 4pm), was located at the end of the road some

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4 For a recent study of precarious housing in Slave Island, see Amarasuriya and Spencer (2015)
500 yards from CommClinic. Samuel had explained that when CommClinic opened, a nearby private dispensary soon closed because it could not compete with CommClinic’s low prices. At Grandpass, however, a private dispensary close to CommClinic remained in business, apparently because many residents had not yet been enticed by CommClinic’s offer of cheaper care.

Our research in Slave Island and Grandpass began with a door-to-door survey, which then provided opportunities for longer interviews. Some simple numbers generated by the survey help to establish patterns of outpatient care in both communities. Our results suggested that of the 66 (Slave Island, \( n = 35 \); Grandpass, \( n = 31 \)) residents we spoke to, 73 percent had used CommClinic service at least once over the previous six months. At Slave Island, 46 percent of respondents said they used the local municipal services when not using CommClinic, compared to just 9 percent who used private services and one who used a mix of public or private. At Grandpass, on the other hand, 36 percent of participants said they used the municipal service, 29 percent used a local doctor’s private surgery, and 19 percent a mix of both. In both communities, CommClinic had become the first option for the majority of residents, with a slightly larger proportion using fee-based services in Grandpass than Slave Island – a difference we suggest reflects the existence of a slightly more affluent population in the former compared with the latter.

Respondents to our survey gave a range of reasons for choosing CommClinic above other services, including its competitive costing (97 percent), convenience (97 percent), and trust (92 percent). Respondents weighed up the benefit of using free public services that were only open during normal working hours and hence might incur lost earnings to attend, versus CommClinic that was also free (but charged for all prescriptions) and was open the evening. In relation to trust, respondents told us they respected the medical staff for their involvement in a charity project; they also focused on the efficacy of the prescriptions they received, which
they said were reliable because CommClinic sourced them directly from the government pharmaceutical service.

Interestingly, just 20 per cent of respondents told us they were aware CommClinic was an initiative of LankaComm, and as many thought a group of doctors had started it as a charity project. However, 60 per cent said they didn’t know. Beliefs ranged widely concerning the motives of whoever was behind the project, from the idea that CommClinic was a business run for profit, a social service run for political gain, a form of *sadaqah* offered by LankaComm’s Muslim owners, or as a “help for the poor people” offered by a benevolent corporation. We detected a slight correlation between those who thought CommClinic was a business and a tendency to trust the service less than those who thought it was some kind of charitable endeavour. Overall, our survey suggested that CommClinic provided the majority of residents with an option that despite a small financial outlay worked out cheaper for people in the longer term. Of the 66 residents interviewed, only two told us they did not use CommClinic at all because it was too expensive. To explore these views further, we turn now to the experiences of three residents, Rizana, Ibrahim, and Farrar.

Forty-three years of age, Rizana lived in Slave Island with her husband and three children in a first floor municipal flat directly opposite CommClinic. Rizana explained the benefits of CommClinic in terms of the three key issues also important to our survey respondents – competitive costing, convenience, and trust. Rizana’s household managed on her husband’s meagre income as a server in a local restaurant, where he earned around Rs.400 (£2.00) per day. Like most low-income families in Colombo, Rizana’s household also depended on loans to meet both short and long-term contingencies, obtained by either pawning jewellery or borrowing cash from local moneylenders. How best to deal with healthcare was thus a real worry. Rizana had to weigh the savings made by using the free municipal service against the time lost waiting for an appointment at the public dispensary; the high charges of a
private evening clinic would make a big hole in the family’s meagre budget. By offering what Rizana described as a “convenient service,” CommClinic provided a realistic third option that, despite a small initial outlay, worked out cheaper in the longer term.

From LankaComm’s perspective, the company had launched CommClinic for people just like Rizana – the Colombo poor who normally incurred financial debts to access basic healthcare but who shied away from resorting to explicit charitable help. Rizana told us she was happy to pay something to access CommClinic’s provision; it gave her the chance “to experience a good lifestyle,” as she put it. Market inclusion allowed Rizana to access (relatively cheap) private healthcare as a consumer, avoiding what she thought of as the shame and stigma of “begging” for healthcare. Nevertheless, Rizana was also aware that the clinic originated from the charity of LankaComm’s founders. She told of her appreciation of those men, and, as a Muslim herself, hoped that Allah would bless them for their kind act in opening the clinic near her home. Rizana explained that the company’s owners had created a relationship with, and an obligation to the community, through their sadaqa. Because of this, Rizana said, no one would complain about the service; she and her neighbours expressed gratitude for the project. As a CommClinic user, Rizana had developed a complex relationship with the clinic. She was neither an empowered consumer, nor a meek recipient of charity. Rather, Rizana’s statements implied that she had come to embody elements of both.

Grandpass resident Ibrahim, 52, was a retired policeman who worked in the Colombo constabulary for some 25 years. He now survived on a government pension, and was the most financially secure person we interviewed in Grandpass or Slave Island. Ibrahim lived with his wife in a three-storey home that his parents had originally built, extending their once simple two-room encroachment into a substantial house replete with middle-class lifestyle furnishings – a tiled floor, widescreen television, and washing machine. One of Ibrahim’s sons worked as a driver in the Gulf, while the other was a government clerk. Both sent money home, and rather
than depending himself upon the charity of others when things became tight, Ibrahim talked of how at Ramadan he liked to give *zakat* to “poor people in the area.” For outpatient medical care, for the past ten years Ibrahim and his wife had used a doctor’s private surgery located a short walk from their home. When CommClinic opened, Ibrahim decided to stay with his existing doctor. According to Ibrahim, this was partly out of loyalty, as the doctor had always provided good care in the past, but also because he viewed CommClinic as extending charity, which was something he was not in the habit of taking.

Contrasted with Rizana, Ibrahim spoke as a person secure in his ability to pay for private medical care. More than this, however, Ibrahim regarded the prospect of using even subsidised private care as something beneath him and demeaning. When asked under what circumstances he might use CommClinic, Ibrahim suggested that only if he could not afford to visit his regular doctor would he consider doing so. On the possibility of using a free municipal service, there was no question – “my sons will always take care of us” he assured us. Thus, for Ibrahim using a fully private outpatient service was an important mark of status, while using CommClinic (or worse, a free municipal service) would have damaged his status. Similarly, Ibrahim stated that he would never countenance the prospect of taking loans for medical care, even though he once did when he was younger and still struggling to raise children and pay for a household on a single wage. The avoidance of both debt and charity was for Ibrahim an important dimension of his ability to retain his self-ascribed middle class identity.

Back in Slave Island, we encountered Farrar, a Muslim woman living in a two-room encroachment in a small lane behind the CommClinic surgery. To earn a living she sold *roti* to a local teashop for Rs.10 (£0.05) each, making around Rs.200 (£1.00) a day. Her husband, a three-wheel driver, earned another Rs.300 to Rs.500 (£1.50 to £2.50) daily. With no wealthy relatives to call on and most of the family’s moveable assets pawned years ago, Farrar and her husband struggled under a weight of debt. As such, when taken ill, they had little option but to
use the free municipal health clinic. This did mean, however, losing time and income waiting for an appointment, extending their economic predicament further still. There was thus little in Farrar’s responses to our questions about CommClinic that expressed any enthusiasm whatsoever about the benefits of subsidised private healthcare. While she spoke about the inadequacy of the municipal service, Farrar still had no doubt it remained a better option than CommClinic’s subsidised yet still expensive private service. “Municipal health service costs nothing, why should I pay CommClinic for it?!?” she asked with notable derision.

For Farrar, CommClinic either attracted fellow residents who had forgotten their right to free medical care, or were far too preoccupied about their status to accept charity. Farrar’s opinion was crucial in exposing something that others we interviewed did fear – that CommClinic would ultimately undermine free municipal services, leaving them only with fee-based outpatient health services. Thus, whether or not people could or should use CommClinic, despite its short-term benefits, was for Farrar tempered by a longer-term and very real worry that healthcare funded through general taxation would ultimately suffer, leaving the poorest like her with no options at all.

The majority of respondents to our survey framed CommClinic just as Bilal, Esmail, and Samuel might have hoped – as an affordable option that emulated the benefits of public healthcare and the ease of private health care. However, the meanings and values they attached to CommClinic scattered according to the diverse economic, social, and political positions of local residents. CommClinic resonated the strongest for Rizana, who passed back and forth between liquidity and debt, finding opportunities for self-advancement through the consumption of CommClinic yet always worrying about its loss. Ibrahim, meanwhile, focused on maintaining his more secure position in the world of fully private healthcare. Farrar, struggling with debt, found CommClinic an unaffordable luxury. How and why people conceived of and understood those possibilities had important implications for service take-up
and satisfaction, and ultimately for the longer-term outlook of the CommClinic programme. It was far from clear whether CommClinic was achieving subjective transformations among beneficiaries of the kind imagined by Bilal and Esmail.

**Conclusion**

At the heart of our story has been a reflection on the problem of definitional consensus under conditions of market diversification and fluidity. As private health providers have gained more ground in a landscape still dominated by publically funded providers, their “unique selling point,” as it were, has been an ability to sell a narrative of *convenience* (short or no waiting times) that has, at least for routine health checks, trumped *trust*, which remains the strength of public and charitable provision. Behind this USP, and underpinning interventions like CommClinic, were shifting and often contradictory ethical stances, aspirations, and practices, from Islamic charity through CSR and social enterprise, to the needs and ambitions informing patient choices within and between private, public, and charitable provisions. What travelled with CommClinic as it passed from LankaComm’s boardroom to beneficiaries in Slave Island and Grandpass were the different possible futures that our informants themselves saw in the organisational and ideational forms taken by the programme. Those forms were never stable and varied according to the aspirations and realities that people held and faced as they sought to make the programme a viable healthcare alternative.

For CommClinic’s founders and managers, economic and social transformation of the poor really appeared to be achievable – *if* users successfully habituated the underpinning ethos of rejecting “handouts” and “paying one’s way.” For some local residents this did appear attractive, while for others it was insulting and politically unpalatable. Such a trade in futures articulated by the ambiguous semantics of service provisions constituted at the interstices of Islamic charity and health consumerism challenged any straightforward reading of what
CommClinic might be or do for its sponsors and users alike. The idea(l) of CommClinic not only failed to travel unfettered from boardroom to beneficiary, at times it did not travel at all. The consequence was an inevitable – and productive – ambiguity over what kind of programme CommClinic was “really” supposed to be.

Thus the “heterochrony” (Ssorin-Chaikov 2006) of CommClinic – the presence of multiple temporalities at work in one location – for us recalls arguments made by both Bloch (1973) and Bourdieu (1991), more recently rearticulated vis. the operations of microfinance by Watanabe (2015), that gifts require specific amounts of time to be actualised as such. Reciprocated immediately, a gift takes the shape of a commodity; reciprocated never at all, and it becomes a true debt. As Graeber (2011) argues, loans and the obligation to pay one’s debts, and charity and the commitment to reciprocate givers’ wishes, are undergirded by the same moral foundations – the responsibility to honour a return. CommClinic’s operational model engendered concomitant cycles of debt and return that sought to allure, if not bind, the Colombo poor to a project of spiritual and economic renewal. At stake was not simply the delivery of health services to a population of the urban poor, but the (re)imagination of the subject of development, and of the relational and moral obligations between givers and recipients.

Yet as we have shown, this endeavour was not straightforward. Aside from “success stories” like Rizana’s, LankaComm’s wider mission was failing – struggling to find footing in the polytemporalities of the health philanthroscape. Bilal and Esmail’s hoped-for future for the poor ran up against Samuel’s risk management strategy that found corporate safety in the charity model. Most of those we spoke to at community level were happy to pay for the service but did not share a common understanding of who was responsible for the intervention, its funding model, or its social mission. Our ethnography revealed a hesitancy among the clinic’s sponsors, managers, and users to endow the intervention with a final interpretation, leaving
open to question its potential or efficacy as a vehicle for promoting the privatisation of healthcare.

Bibliography


http://explore.bl.uk/primo_library/libweb/action/display.do?frbrVersion=4&tabs=moreTab&ct=display&fn=search&doc=BLL01009446484&index=4&recIds=BLL01009446484


Silva, Kalinga Tudor. 2009. “‘Tsunami Third Wave’ and the Politics of Disaster Management


