

USING HUMAN RIGHTS TO ADVANCE SEXUAL AND REPRODUCTIVE HEALTH OF YOUTH AND ADOLESCENTS

*A Tool for
Examining Laws
Regulations and Policies*

Report of the Sri Lanka Field Test



**World Health
Organization**



Ministry Of Health

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**Based on
a tool developed by the
Department of Reproductive Health and Research, and the
Department of Maternal, Newborn, Child and Adolescent Health
World Health Organization, Geneva
in collaboration with the
International Programme on Health and Human Rights,
School of Public Health,
Harvard University**

***In collaboration
with
Ministry of Health and Nutrition of Sri Lanka***

Supported by WHO

2012

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Reproductive Health
of
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Report of the 24 Banks Field Test

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Submitted by WHO

2012

Report of the Sri Lanka Field Test

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
BSS	Behavioural Surveillance Surveys
CACS	Compulsory Attendance Committees at Schools
CAT	Convention Against Torture
CEDAW	Committe on the Elimination of Discrimination against Women
CERD	Committe on the Elimination of Racial Discrimination
CESCR	Committe on Economic, Social and Cultural Rights
CO	Concluding Observations
CRC	Convention on the Rights of the Child
CSW	Commercial sex worker
DV	Domestic Violence
FGM	Female Genital Mutilation
FP	Family Planning
FSW	Female Sex Worker
FWCW	Fourth World Conference on Women
GBV	Gender Based Violence
HPV	Human Papilloma Virus
HR	Human Rights
HRC	Human Rights Committee of the ICCPR
HTP	Harmful Traditional Practices
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IDU	Injecting Drug Users
IEC	Information, Education and Communication
INGO	International Nongovernmental Organization
MCH	Maternal and Child Health
MDG	United Nations Millennium Declaration Resolution adopted by the General Assembly
MO	Medical Officer
MoH	Ministry of Health

MSM	Men who have Sex with Men
NBTS	National Blood Transfusion Services
NCPA	National Child Protection Authority
NCW	National Committee on Women
NDDCB	National Dangerous Drug Control Board
NGO	Nongovernmental Organization
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
OP	Optional Protocol
PHI	Public Health Inspector
PHM	Public Health Midwife
PHN	Public Health Nurse
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
SAARC	South Asian Association for Regional Cooperation
SAMC	School Attendance Monitoring Committees
SAR	South Asian Regional
SLFEB	Sri Lanka Foreign Employment Bureau
SLFPA	Sri Lanka Family Planning Association
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UPR	Universal Periodic Review
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VDRL	Venereal Diseases Research Laboratory (test)
WFP	World Food Programme
WHO	World Health Organization

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Message from the Hon Minister of Health

Sri Lanka is proud of its achievements in the area of reproductive health and has ratified and implemented most of the international treaties that ensure high quality sexual and reproductive health to adolescents and youth.

The government of Sri Lanka recognizes that 5.6 million or 28% of the population comprises of youth and adolescents and fulfilling their needs and expectations is a priority and many programmes have been launched to achieve this end.

This document which analyses policies, laws and regulations related to sexual and reproductive health care provision to adolescent and youth is an important step in identifying what further action is needed to enhance the services provided to them in future.

While appreciating the effort taken, I hope that this document would be a catalyst for positive change in care provision for adolescents and youth who are the Nation's future and hope.

Maithripala Sirisena
Minister of Health
Democratic Socialist Republic of Sri Lanka
Suwasiripaya,
Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

Massage from Representative of World health Organization
Country office Sri Lanka
Dr Firdosi Rustom Mehta

This document has been prepared by three imminent researchers in the field of law, Reproductive health and child and adolescent health using the WHO standard tool on examining Laws Regulations and Policies on adolescents. The Generic tool was developed by Department of Reproductive Health and Research, Department of Child Adolescent Health and Development at WHO in collaboration with the Human Rights Programme at Harvard University's School of Public Health.

This research was facilitated by a National Coordinator and WHO Country office Sri Lanka under a National Working Group consisting of representatives of the Ministry of Health, National Child Protection Authority, independent national experts in the field of law, human rights including child rights and health.

The purpose of the tool is to help countries to identify and address legal, policy and regulatory barriers to adolescents' access to, and use of, sexual and reproductive health care information and services, and to provision of quality services, through a human rights lens. This also helps countries to examine laws and policies to ensure that they are supportive of, rather than a barrier to, adolescents' sexual and reproductive health.

The document identifies many positive policy responses undertaken by Government of Sri Lanka in the area of maternal care, Family planning, Reproductive Health in youth and adolescents. It also identifies how action can be taken within the existing laws and Policies to improve Reproductive Health Care Provision to youth and Adolescents.

Dr Firdosi Rustom Mehta
Representative of World health Organization
Country office Sri Lanka

ACKNOWLEDGEMENTS

This document fulfils a major gap of information that existed and can help policy makers, policy implementers and service providers to enhance the sexual and reproductive health services offered to youth and adolescents of Sri Lanka.

Many individuals and institutions have contributed to this exercise.

We thank WHO/HQ and WHO/SEARO for selecting Sri Lanka to test the human rights tool and providing the direction to complete the study. In this regard we specially thank the members of the WHO Geneva team, Ms.Jane Cottinhham, Marcus Stahlhofer and, Ms.Ezther kismodi and Ms. Neena Raina .

WHO country team headed by Dr.Metha WHO representative for Sri Lanka, extended their fullest cooperation. We express our gratitude to them especially Dr.Metha, and Dr.Anoma Jayathilaka for publishing and making this document available to the public. We would also like to thank Dr.Augustino Bora, the former WHO representative for Sri Lanka, for his support extended during the initial phase of the study.

We are grateful to the Secretary Ministry of Health, who took the responsibility in appointing a coordinator, selecting the researchers and nominating the National working group. We had an excellent research team comprising Prof.Savitri Goonesekere, Dr.Laksmen Senanayake and Prof.Harendra de Silva.

We thank the DDG PHS, Staff of the Family Health Bureau, Director/ YEDD (Youth Elderly Disable and Displaced persons) and all the officials of the Ministry of Health, who willingly and unreservedly contributed by providing information and access to documents. The Ministry of Women's Empowerment and Child Development and many more Ministries and Departments helped us to complete the desk review. We take this opportunity to thank them all.

Our gratitude goes to the National Working Group and the Multi Stakeholders Group who provided their observations and comments in adapting the tool, which in turn helped us to develop a Sri Lanka specific version of the tool as well as prepare the report.

Our special thanks go to Dr Kavinda Wijesinghe for the untiring assistance given to the research team.

Dr. Dula de Silva

Formerly, Deputy Director General, Public Health Services, Ministry of Health

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PREFACE

Integrating human rights across all sectors has been recognized as a major development in the 21 Century. The entire UN system has developed explicit policies and strategies to incorporate human rights in to their fields of intervention. WHO has developed a number of initiatives to use rights based approaches to advance health care delivery systems and the health of people.

The Department of Reproductive Health and Research and the Department of Child Adolescent Health and Development in WHO in collaboration with the Human Rights Program at Harvard University's School of Public Health has developed a tool to examine national laws, regulations, policies and services on adolescents' sexual and reproductive health based on international law relating to human rights.

The purpose of the tool is to help countries to identify and address legal, policy and regulatory barriers to adolescents' access to, and use of, sexual and reproductive health care information and services, and to provision of quality services, through a human rights lens. Human rights compliment the public health approach by enabling a systematic application of human rights principles such as non-discrimination, participation and accountability, to policies and programmes. This also helps countries to examine laws and policies to ensure that they are supportive of, rather than a barrier to, adolescents' sexual and reproductive health, and that law conform to the government's human rights obligations under national and international law.

The WHO Geneva suggested to the WHO office in Sri Lanka that the tool could be field tested in the country. Since Sri Lanka has a long and rich tradition of law and policy making in the area of public health this proposal was accepted in consultation with the Ministry of Health.

The field test was coordinated by a National Coordinator appointed by the Ministry of Health Care and Nutrition. The National Working Group consisting of representatives of the Ministry of Health Care and Nutrition, National Child Protection Authority, independent national experts in the field of law, human rights including child rights and health who had

experience working with governmental and nongovernmental organizations.

Funding support was provided by the WHO.

The first step was to identify the three researchers and adapt the tool to the local context without losing focus of the rights-based methodology.

Prof.Savitri Goonesekere, Dr.Lakshmen Senanayake and Prof. Harendra de Silva, all of whom were recognized professionals in the relevant disciplines were selected for this assignment. The adaptation of this tool was done by the researchers in consultation with the National Working Group. The researchers then applied the tool, collected the relevant material and compiled the data and information. The next step was the analysis of the data and information. The WHO facilitated a two day workshop at which the analysis was presented and discussed. The three researchers then drafted an initial report incorporating the suggestions that emerged in the discussions. The draft report was reviewed at a stakeholders' workshop. The final report was prepared based on this review.

Many thanks to Prof.Savitri Goonesekere, Dr.Lakshmen Senanayake and Prof.Harendra de Silva for their technical knowledge, wisdom and commitment to completing an interesting interdisciplinary assignment.

A special thanks to Dr.Kavinda Wijesinghe for assisting to collect the necessary information and providing clerical support to the research team and National Working Group which facilitated the field test under the coordination of the Ministry of Health Care and Nutrition.

Finally we would like to express our sincere gratitude to the WHO.

We hope that the information and analysis documented in this research, with the recommendations will be widely used and create awareness and action for ensuring that sexual and reproductive health rights of adolescents are respected, protected and fulfilled.

1. INTRODUCTION

1.1. Sexual and reproductive rights of adolescents and youth and human rights.

Reproductive and sexual health is a state of complete physical, mental and social well being in all matters related to the reproductive system. Sexuality is therefore an important issue in the lives of adolescents and young people, as they grow towards adulthood. They have a right to access information and services related to these matters in order to make responsible decisions that will help to ensure their own well being.

Responsible reproductive and sexual behaviour among youth and adolescents was an important recommendation of the ICPD Programme of Action supported by Sri Lanka which celebrated its anniversary in 2010. International human rights instruments also recognize rights relating to reproductive health, without discrimination. Many of them, including the International Covenants, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Right of the Child (CRC) have been ratified by Sri Lanka. Ratification of international treaties creates commitments under International law to introduce laws and policies within the country, to implement these international standards. These international treaties also harmonize with many standards set by the Constitution of Sri Lanka. Though the right to health is not recognized in the Sri Lanka Constitution, other core norms, including equality and non- discrimination harmonize with the international treaty standards.

Sri Lanka is a developing country that has received international and regional recognition for its visionary and pioneering policies that has made a state resourced health and education system accessible to its population without discrimination.

Adolescents too have benefited from these policies as evident in social indicators for both boys and girls. Yet recent research has revealed that adolescents as a group have special concerns, including reproductive health, which needs to be addressed adequately by the health system. The concluding comments of treaty bodies reviewing Sri Lanka's reports to

international treaties including CEDAW and CRC have also highlighted the urgent need to address these concerns in the interests of both adolescents and communities and the development needs of the country.

There is today a growing recognition, internationally and regionally that the human rights framework in International treaties and national Constitution provide an important supportive environment for law and policy reform that can help to eliminate barriers, address gaps, strengthen and support implementation and impact to improve the reproductive health situation of adolescents. In particular laws and policies, reflecting these standards can improve access to services and information and resources allocation to vulnerable groups and impact on the quality and coverage of reproductive health services for adolescent.

28% of the Sri Lankan population is comprised of adolescents and youth. Of the 5.6 Million young people 4 million are school going, 50,000 are enrolled in higher education institutions including universities and 800,000 are estimated to be out of school youth who are either employed or in vocational training institutes or remain under employed or unemployed. Although some policies developed by ministries such as Health and Youth Affairs have strived to address some of the sexual and reproductive rights of adolescents and youth, a human rights analysis provides a useful tool to revisit sexual and reproductive health services, analyse relevant laws and policies of Sri Lanka, and suggest how human rights standards can be used to strengthen the effectiveness of the health system in the specific area of adolescent reproductive health.

1.2. The WHO tool “advancing adolescents' sexual and reproductive health through human rights: strengthening laws, regulations and policies”

As indicated in the documents made available by the WHO, the tool was developed by the Department of Reproductive Health and Research and Department of Child Adolescent Health and Development in WHO in collaboration with the Human Rights Programme at Harvard University's School of Public Health.

The purpose of the tool was to help countries to identify and address legal, policy and regulatory barriers to adolescents' access to, and

use of, sexual and reproductive health care information and services, and to the provision of quality services, through a human rights approach. The tool focused on the manner, in which human rights complements the public health approach by enabling:

- (a) a systematic application to policies and programming of human rights principles such as non-discrimination, participation and accountability,
- (b) an examination of laws and policies to ensure they are supportive of, rather than a barrier to, adolescents' sexual and reproductive health, as well as being in line with the government's human rights obligations.

The objectives of the tool are to assist countries to:

Review and document government efforts to put in place a supportive legal and policy framework related to adolescents' sexual and reproductive health;

Identify legal, policy and regulatory barriers to adolescents' sexual and reproductive health, and make recommendations to overcome these barriers;

Engage health sector, as well as non-health sector, actors to eliminate barriers to adolescents' sexual and reproductive health; and
Identify especially vulnerable groups and examine government effort to address their reproductive and sexual health needs.

The tool consists of a process that follows human rights principles, it is participatory in nature, and needs the involvement of many different stakeholders and consensus building. To use the tool in countries, a process has been elaborated that is participatory and country-led.

The process is intended to be undertaken by the Ministry of Health in a country as an exercise to examine, reflect on and strengthen its laws, policies and programmes relating to adolescents' sexual and reproductive health, with technical assistance from WHO and other partners familiar with human rights and legal and policy issues related to reproductive and sexual health.

To use the tool, three distinct groups with separate roles and responsibilities had to be identified namely, a national working group, a research group and a multi-stakeholder group.

1.2.1. The national working group

The national working group facilitated the field test, under the coordination of the Ministry of Health Care and Nutrition. The national working group consisted of representatives of the Ministry of Health Care and Nutrition, of the National Child Protection Authority, independent national experts in the field of law, human rights and adolescents' health/sexual and reproductive health, non-governmental organizations, youth representatives, and WHO staff.

1.2.2. The research group

The research group was appointed as consultants for this project. They collected information for the tool, conducted a preliminary analysis of the material, assisted in the facilitation of the stakeholder workshop, and prepared the final report according to the WHO tool. They were expected to be independent from the government, and to be individuals with expertise in law, human and child rights, adolescents' sexual and reproductive health and health systems.

1.2.3. The multi-stakeholder group

The members of this group (in addition to the national working group) represented relevant units within the Ministry of Health Care and Nutrition and other governmental institutions/ministries such as Children and Youth Affairs, Education, Social Services, justice, women's empowerment, labor, religion and finance ministries. They included members of non-governmental organizations and civil society, as well as representatives of United Nations Agencies and bilateral agencies, adolescents' sexual and reproductive health advocates, and other organizations dedicated to improving adolescents' sexual and reproductive health and advancing human rights.

Once these structural mechanisms were set up one of the important steps carried out was the adaptation of the tool to the needs country. Adaptation of the tool is essential to allow the country to amend, and if necessary, change, questions or indicators to better match national

data sources. It will also provide countries with the possibility of adding strategic focus on country specific issues and priorities. Data compilation was done by the researchers with facilitation by the Ministry of Health Care and Nutrition and the national working group.

Data compilation was done by the researchers with facilitation by the Ministry of Health Care and Nutrition and the national working group. The analysis of the collected data was done by the researchers together with the national working group, starting with a two-day analysis workshop which introduced the methodology provided in the Users' Guide.

The research team, in consultation with the national working group, prepared the draft report based on the data analysis, which included findings, and proposed conclusions and recommendations.

The final phase of the process involved the participation of the national multi-stakeholders group who reviewed the draft report, conclusions and recommendations made by the national working group.

The final report is expected to incorporate the comments of the national multi-stake holders group and will be published and disseminated.

1.3. The Sri Lanka Field Test

A team from SEARO and WHO Geneva visited Sri Lanka in April 2008 to discuss the feasibility of field testing the tool in Sri Lanka. The Ministry of Health agreed to participate in this activity and the process was started. A senior official of the Ministry of Health was appointed as the national coordinator. The team initiated work in April 2008. After three researchers were selected having expertise and experience in national and international human right law, health policy and health administration relevant to adolescents' sexual and reproductive health.

A two-day orientation and adaptation workshop was conducted for the national working group members and for researchers on the 28 and 29 April 2008. The workshop not only provided orientation on human rights

and adolescents' sexual and reproductive health provided an opportunity to adapt the tool for national use.

Adaptation of the tool allowed the country to amend and change, questions and indicators to match national data sources and information. It also provided an opportunity to add a strategic focus on country specific issues and priorities.

The researchers started the desk review and data compilation in May 2008. As planned, the researchers were able to complete the data compilation by end of August.

An analysis workshop was held in 2nd and 3rd of September 2008 to present the data. The researchers, the National working group and the WHO team participated at the meeting. At this meeting, the researchers were able to brief the National Working Group on the following:

- A comprehensive overview of the legal and policy environment affecting adolescent sexual and reproductive health
- Sri Lankan status on International Treaties relating to reproductive health.
- A comprehensive overview of childcare, adolescent health and women's health services available to adolescents in Sri Lanka.
- Relevant health statistics.
- Current laws policies, legal and policy barriers and service delivery gaps.

The researchers, the WHO team and the National Working Group discussed key issues that surfaced and agreed on the outline for analysis of data in the report. A time frame was also agreed for the writing of the report.

The researchers conducted their analysis and prepared a draft report. This was presented at a workshop on 12th March 2009. Participants included the national working group and the multi stake holder group, selected foreign participants from the region, as well as the WHO team from Geneva and SEARO. The draft was discussed in detail and suggestions and comments were given for the final report. The workshop concluded with a session in which the Minister of Health and senior

officials of the Health Ministry were briefed on the preparation of the report and future steps.

This report presents the analysis and findings based on the human rights framework of the WHO tool and stake holder's consultations. It contains specific recommendations in each area for law, policy reform and programmes. The report seeks to demonstrate that a human right approach based on Sri Lankan constitution and the international obligations undertaken by Sri Lanka as a state party to human rights conventions can strengthen law, policy reform, and interventions that can significantly improve the adolescent reproductive health situation in Sri Lanka.

PART 1

Sexual and reproductive rights of adolescents and youth and human rights.



The Application of Human Rights Standards in Laws and Policies: The Context

International and national human rights standards provide an important framework for law and policy. International standards represent norms that a country has accepted by voluntary ratification of multilateral treaties, or are bound to follow according to “ius cogens” or customary international law. National human rights standards invariably restate international standards and often seek to harmonise them at the national or domestic level. There can however be contradictions which need to be resolved if a State Party is to realize its obligations under International human rights law.

1.4. Scope of International Human Rights Commitments of Sri Lanka

Sri Lanka is one of the countries in South Asia that has ratified all the major international human rights treaties without reservations or declarations. From the 1980s, it has progressively ratified many treaties, including the “Big Seven” – or the core human rights treaties. It has ratified the two International Covenants, (the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic Social and Cultural rights (ICESCR). It has also ratified the Conventions on Elimination of Racial Discrimination (CERD), and the Convention Against Torture (CAT). It has ratified the main international human rights treaties relating to specific groups of persons, such as women and children by ratifying the Convention of Elimination of All Forms of Discrimination Among Women (CEDAW), and the Convention on the Rights of the Child (CRC). Reservations or declarations, procedures that sometimes undermine and dilute Convention standards have usually not been entered by Sri Lanka at the time of ratification.

It will be seen later that disabled persons are a group whose human rights Sri Lanka’s national law strives to protect. Sri Lanka signed the Convention on the Rights of Persons with Disabilities in 2007, but has not yet ratified it.

It has ratified another important Convention that deals with the human rights of a group considered particularly vulnerable to exploitation and abuse – migrant workers. Sri Lanka ratified the International Convention on the Protection of the Rights of Migrant Workers and their families in 1996. In this case, breaking from past practice, declarations were entered to Article 8(2) and Arts 49 and 54, which deal with the subject of visa regulation. A declaration to Art 29 was also entered perhaps because the Convention on Migrant Workers did not harmonize with the provisions of a Citizenship Act (1948) which entrenched discrimination against married women in the transfer of their citizenship to children. This Act has since been amended in 2003 to remove the gender based discrimination, and now also harmonizes with international standards of CRC and CEDAW on citizenship. This declaration to article 26 should now be withdrawn.

Sri Lanka has also ratified the two important instruments that provide for an individual complaints procedure (ICCPR Optional Protocol and CEDAW Optional Protocol), and accepted an international inquiry procedure (CEDAW). Several Communications have been filed by Sri Lankans before the Human Rights Committee under the Optional Protocol of ICCPR, though the CEDAW procedure has not yet been used in Sri Lanka. Sri Lanka has ratified the Optional Protocols to CRC which elaborate on the standards of CRC in specific areas such as trafficking, sexual exploitation, and children in armed conflict.

Sri Lanka has reported to the treaty bodies monitoring these treaties at regular intervals, though there has been some delay in reporting in the case of most treaties. Treaty bodies have issued Concluding Comments Observations and Recommendations which will be considered in dealing with the specific topics discussed in this report.

Customary international law is a body of principles that applies irrespective of treaty obligations. Some principles of the Universal Declaration of Human Rights (UDHR) such as the article on freedom from torture are considered non-derogable principles of customary international law that apply in all countries under international law. Sri Lanka's commitments therefore include the treaties referred to above and these principles.¹

Sri Lanka has participated actively in all the major World Conferences and Summits on Human Rights, relevant to the area under discussion. It adopted the consensus documents of the International Conference on Population and Development (ICPD), Beijing Platform for Action (1995), ICPD+5, Beijing +5+10, the United Nations Millennium Declaration (MDG) Resolution 2000 and the Outcome Document 2004, the World Summit on Children 2000 and the UNGA Special Session on Children UNGASS 2002. Country Programme reports have been submitted to these World Conferences with relevant commitments in this area. For instance, the policy statement to ICPD recognized young people and adolescents as a population group that needs resources for this aspect of health and the importance of addressing their needs and special issues connected with them. Similarly commitments have been made in relation to the Beijing process and UNGASS in country reports. Sri Lanka also reported on the progress on the MDGs in 2005. A similar reporting process and acceptance of commitments was followed by the State in relation to the UNGA Special Session on HIV/AIDS 2004 (UNGASS/HIV/AIDS) 2004.

More recently in 2008 the country was reviewed in the Universal Periodic Review (UPR) process of the Human Rights Council. Sri Lanka's voluntary Commitments at the conclusion of the process refer to strengthening national mechanisms and procedures on human rights through adoption and implementation of a proposed National Plan of Action with targets commencing in 2009, with greater co-operation between government and civil society. It also carries a commitment to appoint the Constitutional Council, the independent appointing authority for major posts under the 17th Amendment to the Constitution. Specific reference is made in the UPR Commitments to advancing children's and women's rights, addressing the special problem of trafficking in women and children, and rehabilitation and reintegration of ex-combatants, particularly children and young persons. There is a commitment made in the document to develop the social, economic and cultural rights of persons in the Eastern Province, and the functioning of democratic institutions in the area. There is a specific reference to commitment to "people oriented" development in poverty alleviation, and achieving the MDGs by 2015 by continued investment in social infrastructure, education and health.²

Sri Lanka has therefore actively participated as a member of the international community in adopting human rights treaty standards and procedures. It has civil society groups that have worked at community level to reinforce international human rights standards. They have often submitted collectively or as individual organizations, shadow reports to international treaty bodies, at the review of the State Party reports of Sri Lanka. The State has not objected to this process. Members of civil society have also offered technical support in the preparation of country reports to treaty bodies, and joined Sri Lankan delegations at World Conferences. Human rights groups including women and children rights activists and groups have not, in general, adopted an adversarial approach to the State, but have been looking to work together with government to advance the agenda.

In recent years, with the military intervention in the North and East, problems of law enforcement and increasing violence across the country, civil society and human rights organizations have raised issues of human rights violations in national and international forums. This has led to allegations and counter allegations on threats, intimidation and extra judicial harassment and killings of human rights defenders from professional and civil society groups. Working with civil society to realize international standards on human rights therefore presents new challenges.

1.4.1. Regional Commitments

South Asia does not have a general document on regional human rights standards. However Sri Lanka has ratified the only instrument currently adopted in South Asia, the SAARC Convention on Preventing and Combating Trafficking in Women and Children in Prostitution (2002). Under international treaty law, the international rather than regional standards prevail in the event of conflict. Therefore even in this area, the International Covenants CEDAW and the UN Declaration on Violence Against Women, CRC and its Protocols must guide law and policy.

1.4.2. National Human Rights Standards and their Implementation

The standards and commitments that Sri Lanka must adopt on human rights at the national level have to be determined according to the national legal system and its structure, and principles of Sri Lankan law on the application of international law.

1.5. Structures of Governance

Sri Lanka has a written Constitution (1978) which sets the basic framework for governance. The law making body is an elected Parliament (the Legislature). However an elected Executive President has administrative and executive power, which he exercises with the support of a Cabinet of Ministers. The Constitution envisages a small Cabinet, but there are no constitutionally specified numbers. Cabinet Ministers are appointed by the government, and over the years the Cabinet has grown to over 100 Ministers.

A career Public Service of administrators assists each Minister in the task of public administration. Appointments to this service were made under the 1978 Constitution by what is expected to be an independent Public Service Commission appointed by a Constitutional Council established under the 17th Amendment to the Constitution³. The Constitutional Council was not appointed for some time and the Public Service Commission has been appointed recently directly by the President. The 18th Amendment to the Constitution passed by the Parliament in 2011 repealed the 17th Amendment. Appointments to the Public Service Commission can now be made directly by the President under the Constitution.

Since the Constitution enshrines the concept of a unitary state⁴ the 13th Amendment to the Constitution accepts a very limited system of devolving powers of governance to the Provinces. Provincial governance is the responsibility of elected Provincial Councils, headed by a Chief Minister from the majority party in the Council. He or she is responsible for the administration, together with other Provincial Ministers and a Governor appointed by the President who acts on their advice.

The legislative and administrative power of the Provincial Councils must be exercised within the framework of the powers of the Central

government under the Constitution and the Provincial Council's Act. There is a Provincial Public Service, and a Provincial Public Service Commission. The devolved legislative power covers subjects placed on a Provincial Council list in the 13th Amendment to the Constitution. However the Central governments control over governance is exercised by the concept of a concurrent list and a reserved list set out in the 13th Amendment where Parliament has the power to legislate in respect of the Provinces. National legislation will then prevail over Provincial Council laws in the case of an inconsistency with the powers of Parliament. Most importantly, the Sri Lankan Parliament has supreme authority and can make laws on matters set out in the Provincial Council list to fulfill international treaty obligations. This is important because the subject of Health and management of all State schools that are not categorized as national schools fall into the Provincial Council list. Besides National policy in health and education continues to be determined by the Central government.⁵

The Constitution incorporates the concept of the separation of powers between the legislature and the executive and the independence of the judiciary. It has established a system of appointment and removal of judges regulated by the Constitution, and a Judicial Services Commission chaired by the Chief Justice. The apex court is the Supreme Court, and there is a Court of Appeal which is a superior Court. Provincial Appeal Courts are now functional because Provincial High Courts which were originally only trial courts have been given an appellate jurisdiction. Lower trial courts such as the Magistrates Court are national courts established throughout the country. The Supreme Court has jurisdiction to enforce fundamental rights enshrined in the Constitution. It will be explained later how the court has interpreted this jurisdiction recently to review legislation passed by Parliament, and also develop a concept of public interest litigation that holds the State accountable for abuse of power in using national resources.⁶

1.5.1. National Human Rights Protection for Adolescents and Youth

The national laws of Sri Lanka are derived from principles of two European systems, the English Common law and Roman Dutch law, as well as local legislation, and some systems of customary / religious local law. These systems have principles which support as well as undermine human rights, and these will be considered later under the cross cutting principles and each topic pertaining to the sexual and reproductive health of adolescents and young people. This section will focus mainly on the rights derived from the Constitution.

It is necessary at the outset to highlight in the discussion the definition of adolescence and youth, since this is pertinent to the analysis of human rights relevant to them, and the discussion that is to follow.

1.6. Definition of Adolescence and Youth

In Sri Lanka a child is defined in the legal system, as well as the Children's Charter 1992, a Sri Lankan policy document that seeks to harmonize Sri Lanka's commitments under the Convention on the Rights of the Child (CRC). The Children's Charter defines a child as a person from birth up to 18 years. The legal definition is derived from the major legislation on the age of majority, and the recently enacted International Covenant on Civil and Political Rights Act (ICCPR Act 2007), which aims to harmonies the ICCPR and CRC commitments. Both these important Acts of parliament which set out the general law of the country define a child as from birth to 18 years.⁷

Adolescence is not defined in Sri Lankan law but there are various definitions of "children" and "young person's" in early legislation, especially colonial legislation.⁸ (Children and Young Persons Ordinance (1939) S 88 defines "child" as a person under 14 years, and a "Young Person" as under 14-16 years; Employment of Women, Young persons and Children Act (1956) defines "child" – under 14 years, "Young Person" 14-18 years)

The Draft National policy on health of Young Persons defines adolescent as person between 10-18 years. **(See note 151)**

The National Draft Youth Policy defines youth as all young women and men between the ages of 15 and 29 years.

Consequently there are contradictions and lack of clarity in the law and policy in regard to definition of adolescence and youth, which must be addressed by introducing a consistent definition in harmony with CRC, into both law and policy.

The definition of adolescence adopted in this study refers to an upper age limit 18 years since the status of majority or adulthood in Sri Lankan Law can now be considered to commence at 18. "Youth" is therefore interpreted in the study as a person above 18 years. An upper age limit for youth has not been identified since Sri Lankan legislation defines youth to refer to different age thresholds above 18 years.⁹

1.7. Treaty Application: Harmonising International Law and Regional Standards

It is necessary to consider the relationship between human rights set out in the domestic law, and their link or relationship to the international treaty standards.

Sri Lanka is a country which follows the English Common law's dualist approach to international law. This means that international law, treaties and regional instruments represent a separate legal regime that applies only if there is incorporation in the domestic or national system, through some method of incorporation such as the Constitution, legislation or executive policy.¹⁰

The Constitution does not establish a procedure for incorporating international law. It confers on the President the power to "do all such acts not being inconsistent with the provisions of the Constitution or written law, or by international law customs or usage he is required to do."¹¹ This reinforces the dualist position that gives primacy to national law. One of the Directive Principles of State Policy declared in the Constitution, which must guide law making and governance, but are not enforceable in the Courts, refers to the "State (promoting) international peace, security and corporation.....and (fostering) respect for international law and treaty obligations."¹² We have referred to the Constitutional

provisions that give the State power to fulfill treaty commitments in its dealings with Provincial legislation. There is therefore recognition of the importance of harmonizing international law even within a dualist legal regime.

The favored method of incorporation of international law has been legislation. The recent Sri Lankan ICCPR Act (2007) seeks to incorporate some ICCPR and CRC rights.¹³ The Torture Act 1994 and legislation on civil aspects of international child abduction, and family support obligations (maintenance) seek to incorporate treaty commitments of CAT, CRC, and the Hague Convention on Civil Aspects of International child abduction¹⁴ However there are also major policy documents, the Children's Charter (1992), and the Women's Charter (1993) meant to harmonize the treaty standard of CRC and CEDAW. It will be observed later that these policy documents have not in fact guided holistic law reform and policy formulation in the manner anticipated. An effort by the Ministry of Women's Empowerment to incorporate the Women's Charter into law through a Women's Act has been on hold for several years, and has not yet come before Parliament.

In this environment, the role of the judiciary has been important. In the recent past, Sri Lanka Courts have created a body of jurisprudence that suggests that international human rights standards including ICCPR and CAT, and even "soft law" such as international declarations from world conferences can be used in judicial interpretation of the fundamental rights guaranteed under Chapter III of the Constitution.¹⁵ The Supreme Court has also interpreted Act 13 (6) of the Constitution which states that criminal legislation can be enacted retrospectively to try and punish crimes "according to general principles of law recognized by the community of nations," to uphold retrospective legislation on hi-jacking, considering this as a crime against humanity under customary international law applicable in Sri Lanka.¹⁶

Despite this judicial trend, a recent case decided in the Supreme Court has adopted a strict dualist approach which has created doubts in regard to the application of international instruments. In the Singarasa Case¹⁷ the Chief Justice questioned the method of executive ratification of the Optional Protocol to ICCPR as an infringement of the judicial power

under the Sri Lankan Constitution, and also held that ICCPR rights could only be enforced in the country if they had been locally incorporated.

The ICCPR Act followed this judgment, but it did not fill the gaps in the Sri Lankan law in harmonizing ICCPR. It contained very few provisions on civil and political rights but contains provisions based on CRC on children's rights. In 2008 the President requested an opinion from the Supreme Court on whether the Sri Lankan legal system was fully compliant with international human rights law. The Supreme Court in its opinion stated that all the core ICCPR rights are available in the Constitution and the ICCPR Act, and no further legislation was required to harmonise the treaty.¹⁸

The authors are of the view that if a strict dualist approach is followed in the Supreme Court in this manner, it will have a negative impact on the scope of judicial interpretation in harmonizing international law. There may even be a reversal of the previous judicial trend and jurisprudence in the Supreme Court supportive of harmonizing international law in the domestic legal system through judicial interpretation.

1.8. Fundamental rights recognized in domestic law

With the introduction of the Constitution of 1978 legally enforceable fundamental rights were defined in several Articles of Chapter III. The focus is on civil and political rights. Aspects such as education, ensuring an adequate standard of living, improvement of living conditions, ensuring social security and welfare are dealt with in a separate Chapter IV, Art 27, on Directive Principles of State Policy. There is no reference to health.

A specific Directive Principle (Art 27 (13)) refers to the State "promoting with special care the interests of children and youth so as to ensure their full development." These Directive Principles can be used to guide law and policy reform, and also the judicial interpretation of legally enforceable Constitutional guarantees on fundamental rights.

The Constitutional provisions on fundamental rights have been supplemented by the legislation incorporating international standards and the jurisprudence referred to earlier. They are reinforced by principles of the Roman Dutch Law and English law on civil liability (Delict) and Administrative Law based on English law. In summary the following rights are recognized:

(1) A right to equality and equal protection of the law. (Art 12)

(2) A right not to be discriminated on the grounds of race, religion, language, caste, sex, political opinion and place of birth is available only to citizens of Sri Lanka. Non citizens have equal right of access to shops etc since these equality rights are available to any person. (Art 12(2) and 12(3))

This constitutionally guaranteed right to equality is reinforced in the Prevention of Social Disabilities (Act 1957), dealing with caste based discrimination and the Rights of Persons with Disabilities Act (1996). There is no specific similar legislation guaranteeing women's rights, or the rights of girl children. However Article 12(4) recognizes a standard of substantive equality or equality that goes beyond formal equality, and includes equality in substance, result and impact. Article 12 (4) provides for affirmative action or temporary special measures to achieve substantive equality on behalf of women, children and disabled persons, and harmonizes with CEDAW Art 4 and CRC Art 2.¹⁹ A proposed Women's Rights Bill, has been under consideration from 2005 but has not yet been placed before parliament. The ICCPR Act 2007 contains some specific provisions on children's rights that will be discussed later.

(3) A right to freedom from torture, cruel and inhuman degrading treatment or punishment. (Art 11).

This article has been interpreted in many cases, including cases of torture of children and assault and excessive punishment of a student, and includes the right to respect for human dignity.²⁰ Art 11 has been strengthened by specific legislation, namely the Torture Act which incorporates CAT in relation to torture and action or inaction by State officials or agencies. Private acts of torture are also covered in the more recent Domestic Violence Act 2005. State inaction in failing to prevent

domestic violence has been included in the CEDAW Committee's interpretation of Violence Against Women. (VAW)²¹ There is local jurisprudence making the State liable for violating fundamental rights by inaction.²² This may be used to argue that there is a violation of Art.11 when a State agency fails to fulfill its duties to prevent domestic violence by adequate investigation and legal action under the laws on domestic violence.

Some specific legislation, the Ragging in Educational Institutions Act 1998, (dealing with acts of torture and harassment in hazing), and the Corporal Punishment Repeal Act 2005 reinforces Article 11 and recognizes a right of human dignity and bodily integrity in harmony with international standards. Art 11 has been more recently interpreted by the Supreme Court in two torture cases as recognizing a right to life and bodily integrity, even though this has not been mentioned as a right in the Constitution specifically.²³ The scope of the interpretation and its actual meaning in relation to human rights standards has not been clarified in areas outside torture. It is not therefore evident that this jurisprudence on a right to life will cover a child's or adolescent's right to survival and development according to CRC.

The civil law of Delict based on Roman Dutch law principles also protects dignity and can reinforce the scope and application of Art 11.

(4) Right to freedom from arbitrary arrest and detention, and retroactive penal legislation (Art 13). This right has also been interpreted to cover the right to human dignity and the right to bodily integrity.²⁴

(5) Right to Freedom of Speech and Expression (Art 14 (1)). This right does not clearly incorporate a right to information, but there is Supreme Court jurisprudence that indicates that this provision may be interpreted to cover the right to "obtain and receive information."²⁵

(6) Right to recognition of identity i.e. as a person before the law. This is not recognized in the Constitution specifically, but has been provided for in the ICCPR Art S.2.

(7) Right to Education.

Chapter III of the Constitution does not set out socio-economic rights. However jurisprudence in the Courts has interpreted Article 12 on the right to equality to include the right of equal access to primary and secondary education and higher education.²⁶ The right of access to benefits of scientific progress may therefore be included by judicial interpretation. A Directive Principle on State Policy Art 27 (2) refers to the State's obligation to "eradicate illiteracy and assure to all persons the right to universal and equal access to education at all levels."

Sri Lanka introduced and resourced a free education policy from 1943 at all levels and this has been implemented through a system of State schools and universities. Today, private institutions offer education in the area of pre-school, primary and secondary education. Tertiary education institutions are mainly State run, though a few private institutions offer limited tertiary education facilities as Board of Investment (BOI) Projects that bring in foreign funding.

A Compulsory Education Regulation (1997) based on early legislation known as the Education Ordinance (1939) requires that all children 5-14 years have access to a school. The ICCPR Act 2007 S 6 (1) (b) now gives every citizen a right of access to basic services provided by the State, recognizing in law the original policy of State delivery of services in the education sector, and making access to education a legal right. This provision has yet to be interpreted in the courts.

(8) Right to Health.

The Right to Health is not guaranteed as a socio-economic right in the Constitution. Health unlike Education is not even referred to in the chapter on Directive Principles of State Policy. A Directive Principle on the obligation to realize "for all citizens an adequate standard of living for themselves and their families including adequate food.

Although according to some scholars the failure to specifically refer to health seems a glaring omission. Sri Lanka has in fact provided and resourced free health services from very early in the 20th century through a system of health care services spread throughout the country.

It has been noted that there is jurisprudence recognizing a right to education through interpretation of the equality clause and a right to life as a dimension of the article on freedom from torture. This jurisprudence may be used to recognise SRH rights such as a right of access to health services including family planning services as a dimension of equality, or the right to life. The ICCPR Act 2007 S. 6(1)(b) now gives every citizen a right to access basic services provided by the State which can be interpreted to cover health. Children's rights are separately defined in S.5, but it can be argued that children and adolescents who are citizens also have the right to basic services in the health sector. Up to now there is no case law in the Supreme Court specifically recognizing these rights.

Some aspects of sexual and reproductive health rights are controversial, and in the absence of a clear statement of such rights in the Constitution it is not clear that they will be included through judicial interpretation. A Directive Principle of State Policy clarifies that "the State shall recognize and protect the family as the basic unit of society." (Art 27 (12)). Constitutionally guaranteed fundamental rights on freedom of thought conscience and religion (Art 10), freedom to manifest religious belief and culture (Art 14 (1)(e), 14 (1) (f) and this Directive Principle on the family may be interpreted in such a manner to reinforce a conservative approach to law reform and policy making in this area. Such an approach can however be challenged, on the basis of the Constitution's approach to the guarantees on religion and culture, that will be discussed later.

(9) Right to Privacy and Informed Consent.

These rights are also not directly recognized and guaranteed in the Constitution or in the ICCPR Act. The ICCPR Act S. 5(2) on children's right to have public and private social welfare institutions, courts, administrative authorities and legislative bodies give paramount importance to their best interests, may be used to support an argument for a child's or adolescent's right to privacy. These aspects will be discussed later in dealing with Cross Cutting Principles in Part II.

(10) Specific Children's and Adolescent's Rights.

This aspect will be dealt with under cross-cutting principles and discrimination.²⁷

1.9. Limitations on Human Rights

1.9.1. General Limitations

The Constitution recognizes that most of the fundamental rights guaranteed in this document, including equality and freedom of speech, can be limited on the basis of several factors, such as racial and religious harmony, national security, and public health, and for “meeting the just requirements of the general welfare of a democratic society.” Art. 15(1) (2) (7). Only the right to freedom of conscience and religion and the right to freedom from torture are absolute. Manifestation of religious belief and culture can also be restricted on the same grounds.

The most controversial limitations that have been criticized in public for a long time relate to censorship regulations and restriction on freedom of speech and in relation to detention and arrest.²⁸ Though the scope of the power of the State to introduce limitations is wide, interestingly, this power has not been used by any government to reform aspects of religious and customary practice that do not harmonise with other fundamental rights or international treaty standards. In this context it is relevant to address two specific issues that have a bearing on the national legal system’s perspective on human rights of adolescents and young people.

1.9.2. Limited Power of Judicial Review

The differing role and responsibility of Parliament and the Courts, has contributed to limiting rights under the Constitution. Article 16 clarifies that past “written and unwritten laws” cannot be challenged in the Supreme Court for violation of fundamental rights thus limiting the power of judicial review of legislation passed by Parliament.

Similarly Article 80(3) clarifies that legislation can be challenged for violation of fundamental rights, only during its passage through Parliament, but not after the legislation is enacted. There have been several challenges before the Supreme Court at the “Bill stage”, when an Act is under consideration by Parliament. Some have been successful. The general consensus in jurisprudence is that the Courts have a very limited power of judicial review of legislation that has been passed by Parliament even when the legislation violates the Constitution, since legislation can be

challenged in court only at the stage when it is before parliament as a 'Bill'²⁹ However in a very recent decision the Supreme court refused to impose a minimum sentence given by the Penal Code (1995) (an Act already passed by parliament) for the offence of statutory rape of a girl under 16 years. The decision is controversial and has been criticized as in conflict with the Constitutional provision limiting the power of the courts to review laws enacted by Parliament. It has been hailed by some as recognition of the power of judicial review of all legislation.³⁰ It is of interest that the ICCPR Act gives paramountcy to the best interests of the child, and the judgment contains no discussion on the implications of the decision for the problem of sexual exploitation of children – the very problem that provided the rationale for the legislative provision on minimum sentences.

1.9.3. Application of Religious and Customary Law

Sri Lanka has only one system of religious law, Islamic law, which applies in the specific areas of family law and inheritance to the Muslim community.

In all other respects, Muslims are governed by the ordinary law of the land, including Constitutional provisions.

Conflicts in the application of the principles of Islamic law and other civil laws have been resolved by the civil courts, which have jurisdiction to hear cases involving Muslims. Consequently principles of the General law on family relations which apply to all Sri Lankans in areas such as custody, guardianship and inheritance, have influenced the development of Islamic law in Sri Lanka. In addition legislation on aspects such as criminal offences and inheritance set out principles which both harmonise with and also replace Islamic law principles. For instance, two Muslims do not have choice to contract a monogamous civil law marriage, and must marry according to Islamic law. The Penal Code recognises polygamous marriages of Muslims by making an exception in the definition of Bigamy so as to make Muslim polygamous marriages legal. However though child marriage is accepted by Islamic law, a Muslim man who has sexual intercourse with a child bride under 12 years can be prosecuted for rape, as this is an offence under the Penal Code (S. 363(e)). Muslims can also adopt children and dispose of their property by a testament or will,

though there are restrictions in regard to both adoption and wills under Islamic law. Sometimes legislation on Islamic law has absorbed principles of the General Law on a man's obligation to support a child born out of lawful wedlock.³¹

In the post 1978 period the internal armed conflict in the North and East has contributed to the development of a strong sense of Muslim identity. Consequently there has been resistance to introduce reform in areas of Muslim law, even when the recommendations have come from moderate groups including women in the Muslim community. It has been observed that the Courts are conscious of their limited power of judicial review of "past unwritten and written law" under Art 16 of the Constitution. Faced with problems of conflict of laws, the Supreme Court, in a case on adoption, gave predominance to Islamic law, thus denying succession rights of adopted Muslim children. In doing so the court did not address the issue of the best interests of the child.³² The government has also up to now not been able to make changes in harmony with its human rights commitments under CRC and CEDAW, despite the fact that both treaty bodies have emphasized the importance of harmonizing Muslim personal law and the domestic standards with international law.³³

As already stated, the right to freedom of conscience and religion (Art 10) is absolute, but the Constitution recognizes the State's right to limit manifestation of religion in the public interest (Art 15 (7)). Successive governments have not used this article to introduce changes in Muslim law in harmony with human rights norms. The current context of ethnic sensitivities has contributed to this situation. Successive governments have taken the view that reform initiatives must come from "within the community." The "community" from a political perspective has in fact been identified as religious and political lobbies. Reform proposals of moderate groups of Muslim citizens including women have not been accepted by successive Governments.³⁴ The same view point was articulated by the Supreme Court in their recent Determination by the court on a Reference by the President, regarding Sri Lanka's laws on civil and political rights. The Chief Justice dismissed an argument made by counsel that the personal laws of the country were discriminatory, and denied women the right to equality. The Chief Justice stated that past laws

could not be challenged or reviewed by Court under Art. 16 and that initiative for reform must come from the community.³⁵

This same legal position applies in regard to changes to customary personal laws of two groups – Tamils of the North governed by a system known as Tesawalamai, and Sinhalese of the Central regions governed by a system known as Kandyan Law. These two systems apply as laws personal to these communities. They contain some principles of both unwritten law and legislation in the area of inheritance and property rights that discriminate against women and limit their economic rights. Reforms in these customary laws can be introduced on the basis of the Constitutional provisions on manifestation of custom and religion. (Art 14 (1) (f), Art 15(7). However as we have noted, even the recent Supreme Court Determination has reiterated that Article 16 of the Constitution limits judicial review of unwritten and past laws. Discriminatory provisions in these laws have therefore not been reviewed by the Courts, or eliminated by legislation, despite public discussion and lobbying by women's groups.³⁶

1.10. Mechanisms for National Human Rights Protection

1.10.1. The Courts

Courts are considered “Upper Guardians” of children with a duty and responsibility to safeguard their best interest (3.4.) Any aggrieved person or his/her attorney may also initiate proceedings in the Supreme Court or apex court to challenge violations of fundamental rights. (Art 126 (1) and (2). Fundamental rights cases can and have been filed by a range of affected persons, including women children and adolescents.³⁷ The ICCPR Act 2007 enables adults as well as children and adults to bring an action in the Provincial High Courts for infringement of rights guaranteed by the Act. (Art 7 (1)).

In the case of children and adolescents, civil legal actions have to be initiated by a “next friend” or adult for the litigation, since they may be considered to be of an age where they do not have “status” or “standing” to litigate under the laws on civil procedure. Criminal prosecutions by contrast have to be launched by the State on complaints made to the police. Proceedings under the Prevention of Domestic Violence Act 2005 can be initiated by a parent or guardian or a person with whom the child resides. A police officer or a person authorised in writing by the National Child Protection Authority can also initiate these proceedings on behalf of the child who is defined in the Act as a person under 18 years.

Proceedings for violation of fundamental rights in the Supreme Court afford the speediest remedy. Non-governmental organizations and private lawyers sometimes offering free “pro bono” services also provide more accessible and affordable services in these proceedings.

Women and child rights groups and activists have not generally used this remedy because they invariably do not have their own legal units, and according to some critics they do not network effectively with mainstream human rights groups. The few who do so invariably move the lower trial courts, in civil and criminal cases.

Young children would obviously not be able to access these remedies unless actions are brought with the support of their parents or guardians as “next friends” or guardians to the litigation. This has also been done in litigation on Fundamental Rights in the cases referred to above. However adolescents have capacity to seek legal advice on their own, even if they have to be represented in court by a “next friend”. Yet all current laws focus on adult representation rather than on adolescent’s independent right to access the justice system. The law should provide for this. They would benefit from legal aid provided by the Legal Aid Commission and NGOs.

The recent recognition of the concept of public interest litigation to encompass persons who are not directly the aggrieved person,³⁸ has made it important for civil society groups working on children's and women's rights to acquire capacity to engage in fundamental rights litigation. Inability to access adult legal aid schemes provided by a State Legal Aid Commission is also a disincentive to adolescents and youth claiming the rights granted by the civil law of Delict, Labour law, the Domestic Violence Act and Criminal Law. These trial proceedings are prolonged for years and are expensive, making these remedies unrealistic without access to free legal aid. The ICCPR Act (2007) S. 5 now gives a child a right to access legal assistance in criminal proceedings. It remains to be seen how this will be implemented.

The Fundamental rights action can be brought in the Supreme Court to challenge State (executive) or administrative action. (Art 126 (1)). However we have noted the jurisprudence in the Supreme Court that has helped to bring private infringements within the scope of the remedy on the basis of the State's inaction.³⁹ Private acts of infringement may therefore now be challenged through this same procedure. Recent jurisprudence has also expanded the scope of the "command responsibility" of those placed in authority, in relation to acts of custodial violence and infringement of fundamental rights. This jurisprudence has strengthened the remedy for infringement of Art 11 on torture, and the rights of children and adolescents to obtain compensation for acts of custodial violence. The development reinforces Penal Code reforms of 1998 that also include a specific criminal offence of statutory custodial rape.⁴⁰ The fundamental rights jurisdiction of the Supreme Court thus continues to provide effective remedies and relief if access to the Court can be strengthened.

1.10.2. Other Bodies

1.10.2.1. State Institutions

The National Human Rights Commission is an independent Commission. It was until recently expected to be appointed by the Constitutional Council under the 17th amendment. The Commission is currently appointed by the President under the 18th Amendment to the Constitution 2011. It has wide powers to investigate complaints and move State authorities to grant relief or prevent violations of human rights. The

Commission can also initiate general investigations, undertake research and facilitate policy reform through their reports.

There are some other bodies specifically established to protect the rights of children and adolescents. Foremost of these is the National Child Protection Authority (NCPA) established by legislation as an independent statutory body. It had a legal unit with committed staff who offered child protection services including investigation of child abuse, providing support services to victims and their families. The task of investigation has now been delegated to the relevant Police Stations. The Authority initially also contributed to law reform, policy formulation and an advocacy campaign, gaining international and regional recognition as a model institution on child protection. However the Authority has since 2005 been placed within the Ministry of Women's Empowerment and Child Development, contributing to a dilution of its status and mandate.

The Women and Children Desks in Police stations throughout the island support the work of the NCPA, and focus on the area of juvenile justice and children in need of protection. They also play a role in enforcing the Domestic Violence Act (2005). There is evidence that they are not adequately resourced in all parts of the country, and that units have been reduced in recent years.⁴¹ They have therefore found it difficult to act effectively to respond to acts of violence against women and children. National women's groups and journalists have addressed the NCPA and the government's gender machinery on specific cases of abduction and sexual violence against adolescent girls, and the impunity with which these acts are perpetrated. They have pointed to the urgent need for an effective "alert system," through which the law enforcement agencies and these Police Desks can act in a co-ordinated manner to investigate violations and offer victim support. The operation of terrorists and para military groups in these areas, has prevented victims obtaining the relief they expect to receive through the official law enforcement agencies.⁴²

Several other official State agencies such as the Legal Aid Commission, established by an Act of Parliament in 1978, the Labour Department's Women and Children Unit and the National Committee on Women, offer limited services of investigation and help to victims of

violations, including women and children who seek their services. The Legal Aid Commission comprises of representatives of the Bar Association. They have now expanded their services to the Provinces and conduct legal literacy programmes. They are also conducting clinics which offer legal advice on accessing government regulatory procedures such as for obtaining Birth and death certificates. Lack of community awareness of these facilities and limited coverage mean that their impact in human rights protection is limited.

Many policy making units within the Ministry of Human Rights and Disaster Management, the Labour Ministry including the Foreign Employment Bureau, the Family Health Bureau, the Ministry of Health, the National Commission on Education and the newly established combined Ministry of Women's Empowerment and Child Development have a mandate to give leadership in co-ordinated human rights based law and policy formulation. The National Child Protection Authority (NCPA) and the National Committee on Women (NCW) have a special responsibility regarding policy formulation to address issues concerning women and children. However these Government agencies do not appear to have networked effectively or co-ordinated their efforts, even though the NCPA and NCW have Boards of Management that could have given leadership and networked to ensure such co-ordination. This has been noted by the CEDAW Committee in its Concluding Comments on Sri Lanka's Report 2002.⁴³ We will note that laws have been reformed and policies put in place in specific areas relevant to children and adolescents, such as child abuse, sexual violence and VAW. These are relevant to sexual and reproductive health. Effective law enforcement victim relief and implementation in this area has not received adequate attention, and there are many contradictions due to the ad hoc nature of these efforts. Sexual reproductive health rights of adolescents and youth have in general received inadequate priority except in the Ministry of Health which has formulated some policy proposals.

1.10.3. Civil Society Participation and Protection of Human Rights

The Constitution guarantees freedom of association. (Art.14). The ICCPR Act now specifically refers to every citizen's right to "take part in the conduct of public affairs." It remains to be seen how this will be

interpreted, and whether it will encourage a positive approach to child and adolescent participation rights according to evolving capacity.

Adolescents in the age group below 18 years and youth or young adults in the age group 18-23 years are treated differently in terms of their participation and involvement in the area of law reform, public policy, programme development and implementation. There has been no sustained effort to involve adolescents, in particular, though 'one off' events like children's parliaments are organized by various State agencies and non-governmental organizations, as well as in schools. There has been no serious or sustained effort in Sri Lanka to realize the participation rights of adolescents under CRC or even accommodate the concept in a holistic manner in the education system. However there are non-governmental youth groups involved in a range of community service and fellowship programmes.

Non-Governmental Organisations of young adults and older persons in Sri Lanka have therefore become the agencies active in pursuing a children's and adolescent's agenda. They have a long history of partnership with government in law and policy reform, programme implementation and service delivery, in areas that have relevance to the sexual and reproductive rights of youth and children. Many of these organizations, particularly professional medical associations continue to fulfil the role. Their members have also worked with government in conflict areas and natural disasters like tsunami. More recently child rights and women's rights NGOs have been established locally and as affiliates of international NGOs. They have developed programmes which are service oriented but also conduct activities that focus on advocacy for policy change, institution building, and law reform. Occasionally they offer some free legal services.

The advocacy and lobbying initiatives of these groups with government have in the past, helped to create a partnership for law reform and policy change in relevant areas of RH such as maternity leave, sexual abuse, domestic violence and HIV AIDS interventions. Government sensitivities to religious lobbies and interest groups has however prevented successful advocacy on other areas, such as abortion, medical termination of pregnancy, sex education in schools and family planning programmes for adolescents.

The participation of Non-Governmental Organizations in policy formulation has been recognized in the policy documents, the Children's Charter, the Women's Charter and the statute creating the National Child Protection Authority (1998). Official agencies with a clear mandate to propose law and policy reforms like the Law Commission and the Human Rights Commission and National Committee on Women also consist of professionals and NGO personnel who serve in their individual capacities. Leading women and children's groups and child rights and gender advocates are therefore often represented in the relevant policy formulation and programme development and implementation authorities. However inadequate resources for these agencies, disruption of institutional continuity and changes in appointments with changes of government have undermined the effectiveness of these bodies. Besides, when there is an environment of disapproval of civil society activism and violence against human rights defenders and media personnel, it becomes a challenge to sustain the traditional partnership with government.

The internal armed conflict and a situation of ineffective law enforcement, has over the years undermined the trust between the State and civil society. Sri Lanka has also a history of conscription of children and youth into radical political movements in the South and the North and East. This is a challenging environment for promoting participation rights of adolescents and youth, particularly since many areas of adolescent RH are controversial.

Cross Cutting Principles for Considering Adolescent Sexual and Reproductive Health

Sri Lanka's ratification of CRC and CEDAW and other international instruments has created an obligation on the State to harmonise the key cross cutting principles of international human rights identified in this section. An analysis of the law and policy environment indicates that there are discrepancies between international standards and national responses which must be addressed in legal and policy reform.

2.1. Non-Discrimination and Formal Equality in Law and Policy General Guarantees of Non-Discrimination in the Constitution and Other Laws

As mentioned initially the age of majority for all children, irrespective of sex, ethnicity or religion is 18 years.⁴⁴ Adolescence is therefore an age below 18 years. Minimum ages in other areas such as work are also generally the same for all children. Minimum age for marriage however is 18 years for all non Muslims since there are differences in Muslim personal law. This aspect will be examined later.

We have noted that the Constitution does not, as in some countries, contain specific provisions on children's rights or the rights of adolescents and youth. Art 12 which sets the core standards on the right to equality and non discrimination does not specifically refer to the aspect of age based discrimination. Art 12(2) only states that "no citizen shall be discriminated on the ground of race, religion, language, caste, sex, political opinion, place of birth or any one of such grounds, limiting the areas of discrimination covered.

However Art 12(1) states that all persons are "equal before the law" and Art 12(4) clarifies those special provisions for all children and young women and girls shall not be considered to violate the standard of equality, justifying affirmative action or positive discrimination to realize substantive equality for these groups. Art 12(1) combined with Art 12(4) therefore clearly indicates that they have a right to substantive equality or equality in result and outcome as holders of Constitutionally guaranteed rights and remedies.

Youth are not specifically referred to in Art 12(4) on affirmative action. Young women are however covered by this Article's (12)(4) reference to affirmative action for women. Some specific legislation such as on Tsunami affected youth (Tsunami Special Provisions Act 2005), family support (Maintenance Act (1999) and the Youth Corp Act (2002) fostering youth participation, provide specifically for State intervention on behalf of all youth above 18 years.

It has been pointed out earlier that children have access to courts to obtain the remedies guaranteed by the Constitution. Fundamental rights cases on the aspect of discrimination relating to children and adolescents have in general been filed in litigation on equal to access to education.⁴⁵ Now that there is jurisprudence recognizing a right to life,⁴⁶ infringements relating to access to health care may become justifiable in the Supreme Court as infringements of the right to equality and life, so as to provide relief and remedy, and promote State accountability in the area of health. Non-discriminatory access to Constitutionally guaranteed fundamental rights remedies for all children and adolescents is therefore a very positive dimension of the Sri Lankan legal environment.

Specific general legislation prohibiting caste discrimination and also recognizing the rights of persons with disabilities reinforce the Constitutional guarantee of non-discrimination. Children adolescents and youth who fall into these categories can also benefit from these legal protections.⁴⁷

Constitutional rights have been strengthened by the inclusion of a dimension of positive discrimination in favour of children and adolescents in Art. 12(4) of the Constitution, and in the recognition of specific rights of children and adolescents, in the recent ICCPR Act 2007. The rights recognized in the ICCPR act are limited in scope. A specific general provision S.2 provides for recognition of a child or adolescent "as a person before the law" – which include the right of all children to recognition of their identity. There is also a provision (S.5.(1)) specifically recognizing rights of all children including adolescents to birth registration and a name, nationality, protection from maltreatment, neglect, abuse or degradation, and legal assistance by the State in criminal proceedings if substantial injustice would otherwise result. A right to have their best

interests given paramountcy in interventions of all agencies in matters concerning them (S. 5(2)) reinforces these rights. The ICCPR Act recognizes citizen's rights to take part in public affairs and have access to services provided by the State, but it is not clear that this refers to citizen children. The ICCPR Act 7(5) however does clarify specifically that children have the same access to the High Court to enforce these rights, thus expanding the scope of remedies for rights violations provided currently in the Supreme Court.

These provisions of the ICCPR Act may be considered "affirmative action" to realize substantive equality for all children and adolescents and prevent discrimination and marginalization of their interests. The two other examples of such recent legislation, deal with Tsunami affected children, adolescents and youth, and providing support and maintenance for these groups. The Youth Corp Act (2002) fostering youth participation provides specifically for State intervention on behalf of youth.⁴⁸

The Children's Charter 1992, the policy document based on CRC also states the universal standard of non-discrimination and all rights for all children including adolescents.⁴⁹

The recent jurisprudence in the Supreme Court on a right to life, together with the criminalization of infanticide, abandonment or concealment of death of a child and adolescent, recognize the right to survival.⁵⁰ These laws have been supported by social policies and resource allocation to provide universal access for all children and adolescents to birth registration, free education and free health. The discussions on and the situation on health, birth registration and education will reveal that in general, the right to identity and development rights of all children in regard to education and health have been recognized in both law and policy and also implemented. The Citizenship Amendment Act (2003) eliminated discriminatory aspects in the main legislation of 1948 and enables all children to acquire citizenship through a citizen father or mother. The ICCPR Act (2007) S.5 now clearly recognizes every child's right to acquire a nationality.

The above discussion, as well as later discussions on sexual and reproductive health will indicate that there has been considerable efforts

from the 1930s to recognize the protection rights of some groups of children and adolescents who are especially vulnerable to exploitation and abuse. Juvenile justice and child employment laws specifically address the protection rights of children in conflict with the law, or children at risk of exploitation and abuse or intra family disruption.⁵¹ Recent reforms to the Penal Code (1883) that will be discussed later, have strengthened the law on prevention of child abuse and sexual violence and exploitation. These laws reinforce the fundamental rights jurisprudence on torture in litigation involving children, referred to earlier, and the ICCPR Act which clearly sets out the right to protection in the language of CRC. A ban on corporal punishment in sentencing in courts was introduced by an amendment of 2005. There is jurisprudence in the Supreme Court recognizing that sexual and physical violence and use of corporal punishment in schools could amount to torture. We shall also note later that new Education regulations prohibit use of corporal punishment in schools, while a recent act of parliament has prohibited corporal punishment in sentencing.⁵²

Enforcement of these Laws and policies has been strengthened by the creation of a National Child Protection Authority with a specific protection mandate to facilitate monitoring and implementation of protection rights. The Women and Children's Police Desks, and the National Human Rights Commission referred to in Chapter I also address protection issues. The former is the specific law enforcement agency established to realize protection rights, the latter a human rights protection institution that has taken on selective issues of child protection.⁵³

The concept of participation rights of children and adolescents in the Sri Lanka law aims to balance protection and participation rights, resulting in a limitation of their participation rights. The ICCPR Act (2007) incorporated child rights but does not refer to participation rights.⁵⁴ Details that cover the scope of particular participation rights and responsibilities, depending on evolving capacity will be discussed later. Children and adolescents are in general differentiated from adults in the area of political participation. The Constitution guarantees right of peaceful assembly, freedom of association and trade union rights (Art 14(1) (b) (c) (d)). However adolescents do not have political rights since the right to vote at elections for legislative authorities can be exercised

only at 18 years. Trade union participation is limited to adolescents above 16 years.⁵⁵

Conscription of a child under 18 years for participation in armed conflict was made a Penal offence in 2006.⁵⁶ The Children's Charter (1993) declares a State Policy on a child's right not to be recruited to the armed forces,⁵⁷ and the State has adhered to this in its recruitment policy. However adolescents have in fact been involved in youth insurrections and radical political movements and terrorist violence in Sri Lanka. The protection ideology prevails in the area of international children's rights, as reflected in the Optional Protocol to CRC and later development in the UN on zero tolerance for conscription of children. The concept of an age of discretion and evolving capacity does not make such participation lawful.

This strong foundation of State initiatives to recognize Constitutional norms and international standards on human rights and non-discrimination contributes to a positive scenario on equality and non-discrimination. We have noted that rights are articulated in gender neutral terms, as a set of universal standards applicable to all children and adolescents.

2.2. Discrimination in Specific Areas of Law

Despite this strong foundation of formal equality in Sri Lankan law, there are specific areas in which discriminatory laws and policies of an earlier era that conflict with the later laws and Constitutional standards continue to apply. These contradictions have not been re-examined and eliminated in legislative and policy reforms. The application of personal laws based on ethnicity locations and religion in the case of some communities, and the inability of successive governments to introduce reform due to the sensitivities created by ethnic and religious lobbies, also result in a denial of the same rights for children from all communities.

2.2.1 Gender Ethnicity and Religion

Since there is a Constitutional guarantee on equality without discrimination on the basis of sex, (Art 12) and legislation on children's human rights that is gender neutral and applicable to both boys and girls, there is formal equality without sex discrimination in the law.

Some provisions in child labour law however differentiate between girls and boys in regard to vocational training, on a protection rationale. These need to be reviewed.⁵⁸ The jurisprudence that has developed on the “age of discretion” at which a child acquires decision making powers also discriminates against girls. This is specified in case law as 16 for girls and 14 for boys.⁵⁹ However since there is no specific legislation on this aspect, and 16 is recognized as the age of evolving capacity in other statutes that will be referred to later, it may be argued that 16 is the common age of discretion for both boys and girls in the Sri Lanka legal system.

Girls who belong to the Tamil community governed by the personal laws known as Tesawalamai or the Sinhala community governed by a customary system known as Kandyan law have less right to inherit family property. Young Tamil married women governed by this system are also subject to the husband’s marital rights in relation to legal standing, transfer of immovable property and capacity to enter into contracts.⁶⁰

These gender based differences in the personal laws conflict with the Constitutional guarantees on equality. The provisions on the husband’s marital power conflict with S. 2 of the ICCPR Act (2007) which recognizes the right of every person “to be recognized as a person before the law.” Efforts by women’s groups to lobby for reform have not been successful due to the perceived “sensitivity” of these issues. The recent determination of the Supreme Court on a reference by the President reinforces the view that Art 16 of the Constitution also does not permit the review of customary or personal laws.⁶¹

The problem of eliminating the discrimination in legal norms is even more complex in the case of the Muslim community. We have noted that the Constitution guarantees freedom of religion (Art 10), but also gives the State the right to limit manifestation of religion in practice in the interests of public order, etc. This Article has never been interpreted as authorizing intervention in this area, though in the colonial era general legislation applicable to Muslims was enacted.⁶²

Muslim personal law in Sri Lanka contains various provisions on the advancement of majority at the age of puberty, marital power of the husband, inheritance rights, dowry property, management of property and

child support which differentiate between the legal status of boys and girls, young men and young women. There is also no minimum age of capacity to marry (minimum age of marriage) for boys or girls as in the case of all other Sri Lankan children. This means that child marriage is considered legal in Muslim personal law. There is some legal provision for recording the bridegrooms consent, but no legal requirement of the bride's consent, though this is a vital requirement of marriage laws applicable to other communities.⁶³ The concept of marital rape after a judicial separation on a court order as a criminal offence is accepted in the case of all other communities. When the law was amended in 1995 to create an offence of marital rape during legal separation, a provision in colonial Penal Code of 1883, which introduced this offence as a deterrent to child marriages where the girl was under 12 years, was retained. This means that in the case of Muslims who may still contract child marriages marital rape is committed only when the girl is under 12 years of age.⁶⁴ Muslim women's groups have agitated for reform of many of these provisions, but their efforts have not been successful.⁶⁵

2.2.2. Non Marital and Adopted Children and Children in Foster Care

Sri Lankan laws derived from two colonial systems, the English law and Roman Dutch law, created a concept of "legitimate" and "illegitimate" children based on the legal status of their parents union as marriage or informal cohabitation. This concept of the child born out of wedlock as "illegitimate", conflicts with both Constitutional and international human rights standards.

Some important recent legislation on child support and citizenship enacted after lobbying by child rights and women's rights activists, has eliminated this discrimination.⁶⁶ However the differentiation and the diminished status of non-marital children due to their biological link to an unwed mother continues in non-statutory Roman Dutch law principles of custody, guardianship, inheritance and private property rights.⁶⁷ Some of the discriminatory values that were introduced into customary Kandyan personal law in the British colonial period also have not been changed.⁶⁸ There is an urgent need to follow the recent reformist legislative trend to eliminate discrimination and harmonise this area of law with Constitutional and international standards.

The Births and Deaths Registration Act (1951) in Sri Lanka provides for registration of the birth but elicits information on marriage and paternity. The ICCPR Act recognizes a specific right to identity as a person, a name, and birth registration.⁶⁹ We shall see later in discussing birth registration that proactive policy measures are necessary to prevent discrimination against non-marital children, whose status is indicated in the birth certificate when they seek admission to State schools. Parents may not be willing to submit birth certificates that reveal their unmarried status, but school admission will require a birth certificate.

Adopted children and children in foster care have in general equal rights, and recent reforms have introduced specific provisions to prevent exploitation and abuse of these children including through child care arrangements after the Tsunami.⁷⁰ However there are some provisions on inheritance in the Adoption Ordinance of Sri Lanka that discriminates against adopted children, and jurisprudence in the Supreme Court denying equal inheritance rights to adopted Muslim children.⁷¹ These dichotomies need to be eliminated to realize the standard of non-discrimination. Similarly the Muslim personal law values on non-marital children present a barrier to realizing the norm of equality, even though some branches of this law like child support in Muslim law have already been harmonised through interaction with the general law on maintenance.⁷²

2.2.3. Age Based Discrimination

Differentiation in rights surfaces in Sri Lankan law when certain age groups are treated differently in regard to their rights because they fall within a particular age threshold. The international human rights and Constitutional standards on equality permit positive discrimination and also differences based on a reasonable classification that helps to achieve equality in impact. However in Sri Lanka, the age thresholds have been decided in an arbitrary and ad hoc manner, without any consistency.

For example, only a child of 14 can be adopted, but custodians can be registered in respect of all children and young adult persons between 18-21 years orphaned by the Tsunami.⁷³ Jurisprudence recognizes an “age of discretion” for autonomous decision making at 16 years, but the legislation on organ transplants permits a parent to donate the

regenerative tissue of an adolescent, or youth between 18-21 years for the purpose of a transplant after death or during life time to another member of their family.⁷⁴ The ICCPR Act clearly recognizes an adult citizen's right to access basic services provided by the State, but does not clarify whether children can do so.⁷⁵ Parental consent is required for the marriage of youth above 18 years and below 21 years, even though they acquire capacity to marry at 18 years.⁷⁶ All these provisions need to be reviewed and rationalized for consistency in law and policy, and harmonized with the norms on child rights and non-discrimination. Age differences must be justified, either on the basis of a child's development and/or child protection rationale. Since all these provisions require review, the MoH can make a contribution by networking with relevant agencies to introduce change.

The right to employment is sometimes considered an aspect of the rights of adolescent children, because of evolving capacity. Consequently laws that prohibit employment can be perceived as discrimination. However international standards of CRC and ILO prohibit child labour below a specified age threshold on a child development or child protection rationale. This approach is reflected in Sri Lankan law.

Sri Lanka has always placed restrictions on child labour which can be harmful to general health and sexual and reproductive health. Child workers are also at risk of sexual abuse and exploitation which can impact on reproductive health. In Sri Lanka child employment below the age of 14 years has been prohibited. Adolescents and youth above this age have a right to work, but there are restrictions based on the need to protect them from occupations that are prescribed as hazardous and harmful to "health, safety and morals."⁷⁷

Originally there was a difference between male and female adolescents and young person's regarding night work, since all women were prohibited from night work. This ban was removed by amending the law in 1984. Night work can now be undertaken by adolescent girls and young women, but it is subject to restrictions placed by law in the case of both males and females above the minimum age for employment, but below 18 years. Some provisions continue to set different standards for males and females, even under this age group in the areas of vocational

training at night. These restrictions are justified on a “protection” rationale. Restrictions have also been placed on children under 14 years taking part in entertainment. No child under 18 years can take part in public performances which endanger life and limb, or in performances of a dangerous nature, though this is permitted in case of adolescents between 14-18 years, subject to a regulated system of licences.

2.2.4. Non-Citizen Children and Illegal Immigrants

The Constitution guarantees certain important rights (e.g. non-discrimination, freedom of speech, freedom of association) only to citizens. The ICCPR Act (2007) now makes clear that the right to participate in public life and obtain access to services provided by the State is limited to citizens. The Constitutional provisions limiting some rights to citizens have been the subject of adverse Concluding Observations by the ICESCR Committee in 1998. The Committee also referred to discrimination against non-citizens of Indian origin etc. in access to basic services such as health and education.

There is no evidence that in practice non-citizen adolescents and children are denied access to State schools or health services which are non-fee levying.

Legislation enacted in 2003 provided for the granting of citizenship to hitherto ‘stateless’ persons of Indian origin (mostly plantation workers). This addressed some of the concerns expressed by the ICESCR Committee regarding persons of Indian origin.

2.3. De Facto Discrimination and Vulnerable Groups of Children

The situation analysis in Chapter. III will reveal that in Sri Lanka, free health and education services including RH services are available to all without discrimination. Despite these resources and the solid foundation of law and policy discussed above, inadequacies in implementation result in some vulnerable groups not benefiting. The reasons can be varied – poverty dysfunctional families, gender based violence, the armed conflict, resulting in displacement and breakdown of law and order and disruption in delivery of services in these areas and increasingly inadequate resource allocation for rural schools, hospitals and shelters for child victims of abuse. It is clear that affirmative action or special measures are required

to enable these vulnerable groups to enjoy the rights guaranteed to others. Despite the Constitutional provision of Art 12(4) authorizing such measures in general, these vulnerable groups continue to remain disadvantaged. These groups may be identified as:

2.3.1. Children and Adolescents of Low Income Families

These children and adolescents confront the problem of family poverty. They can be members of various ethnic and religious groups. Some of these children belong to families where child care is inadequate. They are school drop outs and frequently exploited in child labour and poor conditions of work. They engage in a variety of occupations in the informal unregulated sector including in domestic service. Compulsory education regulations to encourage school participation and providing access to regular schools, vocational schools and remedial education, have been highlighted in policy interventions and programmes of the ILO/IPEC. The State and child rights organizations also focus on improving health and alleviating family poverty.

Adolescents and youth from low income families of Indian Tamil origin in plantations have been identified as a special group affected by poverty that has to be provided for in policy interventions. These interventions try to address the problem of persisting regional variations and low health and education indicators for this group.⁷⁸

2.3.2. Refugees / IDPs

There are no special laws to cover these population groups but many programmes by the State and civil society organizations address these children who belong mostly to the Tamil and Muslim community affected by the armed conflict in the North and East.

2.3.3. Street Children including Children Offering (used for) Commercial Sex

Children who live in streets in Sri Lanka belong to slum communities with a relatively stable life style, or are children exploited by adults in begging on the streets.

In 1998 and 2006 the laws were strengthened to criminalize the conduct of adults who exploited children in begging or in drug trafficking.

However children continue to be seen with adult beggars on the streets in major cities. Girls involved in street prostitution are particularly vulnerable to be picked up and remanded in shelters or sentenced to imprisonment for 14 days due to the severity with which the police enforce a colonial law – the Vagrants Ordinance (1841).

Programmes by the State and civil society groups for slum communities and improved income levels and shelters with the support of family members of overseas migrant workers have created a relatively stable life style for some children in slum communities. However family disruptions and child abuse often occur, and research suggests that they are at high risk in this respect.⁷⁹

2.3.4. Children and Adolescents in Shelters and Institutions and Detention Facilities

Shelters are managed by the State as well as by civil society organizations. Child victims of abuse and children in conflict with the law are placed in these institutions. Children's rights are respected only to the extent that the institutions are well managed.

There have been newspaper reports of child abuse in these institutions and inquiries. Research studies indicate that services in health and education are uneven, and that there is risk of child abuse. One of the additional problems is the long delay involved in legal proceedings on child abuse. Children have to be taken up and down to court and are sometimes transported in prison vehicles. The absence of child friendly legal proceedings is a significant gap that the National Child Protection Authority has not been able to address.⁸⁰

2.3.5. Children of Low Castes and Indigenous People

Children of all castes have access to health and education. A micro study of the Centre For Women's Research Colombo found some evidence of poor facilities and a curriculum linked to an occupation based on caste in some schools in remote areas.⁸¹ Special programmes have been conducted to improve the health, nutrition, and status of children of an indigenous community, and mainstream them into the State education system.⁸²

2.3.6. Homosexuals and Transgender Persons

Homosexual acts between men were illegal and described in the language of early English criminal law as unnatural acts. They were considered criminal offences in Sri Lanka in the Penal Code S 365 A. A proposal to decriminalise adult homosexuality that was made in 1995 was not accepted. However section 365 A was amended in 1995 and now refers to “a person” thus broadening the offence including the conduct of both men and women within the scope of the criminal offence of homosexuality.

Despite this approach to homosexual acts, changes have been introduced in regard to the age of sexual consent for girls and boys. In 1998 the Penal Code was amended and now recognizes that there is a common age of sexual consent for boys and girls at 16 years. Statutory rape is heterosexual intercourse with a girl below 16 years. The relevant age of consent to the separate offence of grave sexual abuse is 16 years for boys and girls. Consequently a sexual act with a boy or girl above 16 years of age cannot be considered grave sexual abuse against either boys or girls if it is with their consent.⁸³ This provision therefore creates a conflict with the Penal Code S. 365 A criminalizing homosexuality and imposing an absolute legal prohibition of such conduct.

The law prohibiting and criminalising homosexuality between consenting adults conflicts with the Constitutional and international human right standards. However it should be noted that the criminal law is not in fact enforced with prosecutions. There is anecdotal evidence of instances where children have been expelled from schools for homosexual conduct on decisions taken by some principals of schools. These decisions do not appear to have been challenged on the ground that adolescents have a right of equal access under the Constitution to health and education services in both State and private institutions irrespective of their sexual orientation.

2.3.7. Children and Adolescents with Disabilities

There are no specific laws and policies to address the vulnerability to discrimination of children and adolescents with disability, despite the fact that Art 12(4) of the Constitution, referred to earlier, provides for

affirmative action or special provisions to ensure that they have equal opportunities.

Some protective measures have been introduced in the area of child abuse through an enhanced punishment for rape of a girl or woman with disabilities.⁸⁴ Legislation on Protection of the Rights of Persons with Disabilities (1996) establishes a National Council to promote and advance rights of the disabled and also recognizes some specific rights. This legislation has a short Part on the rights of these persons, and recognises rights of admission to educational institutions, and access to and use of buildings without discrimination.⁸⁵ The Council or the person concerned may obtain relief and redress for a violation of these rights through the High Court and the Court may grant just and equitable relief.⁸⁶ These provisions supplement the general relief available for discrimination in violation of the Constitutional guarantees or the specific rights recognized under the ICCPR Act (2007) discussed earlier.

In general Sri Lanka has followed a policy of integrating children and adolescents with disabilities including visual disabilities into the State education system. However caregivers and activists provide anecdotal evidence that state schools do not always have a supportive environment. Private organizations and non-governmental organizations offer various services to children with special needs.

2.3.8. Adolescents who are Sexually Active – Access to RH Services

The lack of adequate RH information and access to contraception, resulting in teenage pregnancy and sexual abuse place both boys and girls especially from low income families at risk. Pregnancy can result in disruption of schooling unless the family is supportive or the National Child Protection Authority services for support are accessed. This aspect will be discussed in the section on access to health information.

2.3.9. Girl Children

Girl children have not been identified by law and policy in Sri Lanka as a group that is especially vulnerable, unlike in other countries in South Asia, because of the insignificant of disparities in social indicators on nutrition, health and education.⁸⁷ However studies on child abuse, domestic violence and sexual exploitation suggest that adolescent girls

and girl children are exposed to specific forms of gender based violence such as rape, incest, exploitation in domestic service, trafficking and prostitution. This aspect will also be discussed in the next chapter.⁸⁸

2.4. Best Interests and Evolving Capacities of the Child and Respect for Views

Sri Lanka has an impressive range of laws and policies guaranteeing the crucial norm of best interests in child rights. It also has a range of laws and policies that harmonise with the international standards on a child's evolving capacity, recognizing the importance of hearing the voice of children and adolescents. Yet it has been observed that practical implementation of the standards poses problems which have not been addressed.

2.4.1. Legal Standards on Best Interests

The principle is not reflected in this specific language in the Constitution. However Art 27(13) of the Directive Principles of State Policy refers to the obligation of the State to “promote with special care the interests of the Children and Youth to ensure their full development and protection from exploitation and discrimination.” **When Sri Lanka adopted the policy document known as the Children's Charter in (1993) it incorporated a provision on the best interests of the child, in the same language of the Convention on the Rights of the Child (CRC). (Art 3). Fifteen years later the ICCPR Act 2007 s.5 (2) has incorporated the language of Art 3 of CRC and states that “the best interests of the child must be given paramountcy in all matters concerning children”. S.5 (2) states that in all matters concerning children whether undertaken by public or private social organisations, courts, administrative authorities or legislative bodies, the best interest of the child shall be of paramount importance” This standard is now clearly incorporated into law.**

The focus on the “welfare of the child” and respecting his/her wishes depending on their evolving capacity in decision making on juvenile policies and adoption is found in early colonial legislation, and remains in these statutes today. [Adoption Ordinance 1941 s. 4(b) Children and Young Persons Ordinance (1939) s.9, s.21] The recently enacted legislation on Civil Aspects of International Child Abduction (2001) s.11 (1)(b) accommodates the concept of interests of the child or their welfare.

The Domestic Violence Act (2005)s. 11 (f) 11 (2) empowers the Court to restrain a respondent's contact with a child in the "interests of the child." The Tsunami Special Provisions Act (2005) s.14 (5) introduced the concept of giving paramountcy to the best interests of the child and respect for the child's or young person's wishes in determining foster care placements relating to children and young person's affected by the tsunami disaster.

The Sri Lankan legislation reflects the legal position taken in many court cases on custody from the time of colonial period. **The paramountcy of the child's welfare / best interests is a core principle of the Roman Dutch Law on guardianship which places the court in the position of an Upper Guardian of children tasked with protecting their interests, "parens patriae" or on behalf of the State. The concept of the Courts upper guardianship of children is recognized in legislation on the jurisdiction and powers of the courts, and referred to recently in the Tsunami Special Provisions Act (2005).**⁸⁹

(Most recent case, in the Supreme Court Jeyarajan v Jeyarajan (1999) (90)

The appeal courts of Sri Lanka deciding custody cases and applying Roman Dutch Law have equated "best interests of the child" with a norm of "protection of life health and morals of the child." They use this language citing leading South African cases interpreting the Roman Dutch Law. The jurisprudence reveals that "best interests" is often interpreted in the context of competing custodial interests of parents or foster parents, i.e. who will be the better parent? Sometimes the views and wishes of the child depending on his/her maturity and evolving capacity are accommodated within the concept.

There are no specific studies on administration of juvenile justice or adoption which indicate that there is child centred decision making using these concepts. Available studies on the legal process and children suggest that court decisions in these areas depend on the individual approach adopted by the particular judge. (90a) The absence of a check list and guidelines as in some other jurisdictions is a major gap in implementing the standard of best interests incorporated in legislation and jurisprudence in the area of custody and guardianship. There is also no clear procedure for ensuring that the child's views are heard. They are often conveyed by lawyers or parents to the Court. The recently enacted

Tsunami Special Provisions Act is the first legislation to address this problem and provide a check list in a schedule to the statute on foster care placement. Even this legislation has no procedure for ensuring that the child or young person is consulted and consent is obtained. There is no detailed evaluation/screening system for suitability of adoption as in western countries. What is usually accepted in the courts is a letter from the department of probations that may have made the assessment on superficial scrutiny.

Non Discrimination has been addressed in jurisprudence in the civil courts that applies the best interests' concept in custody litigation among Muslims, as well as others governed by the personal laws. This has helped to forge a uniform jurisprudence on the right of the Courts to interfere with parental and guardianship rights in these personal laws in the best interests of the child, despite the diversity in the personal law value systems. However Courts determining custody disputes in the case of non-marital children interpret the concept of best interests within the discriminatory law of custody, which focuses on the exclusive parental rights of the mother, and exclude the father altogether.

Reference: (91)

2.4.2. Evolving Capacity and Respect for the Child's View

As discussed earlier there is jurisprudence on a child reaching "age of discretion," and statutory provisions to ascertain the views of a child according to "evolving capacity" and according to a flexible standard that takes into account the "age and maturity of the child." These conform with CRC. However there is no procedure to ensure that the right is exercised or the standard implemented. Therefore there appears to be large area of judicial discretion in this regard.

Summary of Provisions

Consent to Adoption and Foster Care in Tsunami affected children 10 years, Adoption Proceedings (10 years to 14 years), Juvenile Justice (16 years), Sexual Relations (16 years), Kidnapping from "Lawful Guardianship" – 16 years(girl) 14 years (boy), Marriage – Parental Consent (up to 21 years), Donation of Organ – (Parental Rights up to 21 years).

The last two laws were passed before the age of majority was lowered to 18 years and are in conflict with CRC concept of evolving capacity, and age of majority and status of youth as “young adults,” at 18 years according to Sri Lanka’s Age of Majority Ordinance, and the recently enacted ICCPR Act 2007, s.10 which defines child as a person under 18 years.

The concept of the “age of discretion” developed in jurisprudence on custody, which differentiates between boys and girls (14 for boys, 16 for girls), is in conflict with CRC’s concept of evolving capacity and non-discrimination.

References: (92) (93) (94); (95) (96) Transplantation of Human Tissue Act (1987) s.23 defines child as a person under 21 years, and both parents or in some circumstances one parent or guardian “may file his consent in writing for donation during life from the body of the child for the purpose of transplantation of such tissue to the body of another member of the family of such child” (s.8) **(97), (98)**

2.4.3. Parental Rights and Responsibilities and the Child’s Evolving Capacities

Sri Lanka’s law on parental and guardianship rights is derived from a mix of non-statutory Roman Dutch Law and English law (received Colonial law), personal law, and legislation relevant to children (juvenile justice, civil aspects of international child abduction, adoption, foster care, maintenance, education). All these laws emphasize parental and guardianship/custodial rights and the preferential or “natural” guardianship rights of the father of children under 18 years, born within marriage. The mother of children under 18 years is deemed the preferred “natural guardian” of non-marital children, described in early legislation and jurisprudence as “illegitimate” children.

Parental guardianship and custodial rights are however circumscribed by the concept of parental responsibilities relating to minors in regard to child care, management of property if any, support, education, (compulsory education regulations apply to parents), and the duty to protect them from exploitation and abuse. These concepts are also found in non-statutory principles of Roman Dutch Law and English law,

and legislation in the above areas as well as the Penal Code and Children and Young Persons Ordinance which deal with child abuse. The Child Employment Laws reinforce obligations to give access to education, avoiding exploitation of the child in employment in the home, or outside.

As mentioned in 3.4.1. there is an overriding concept derived from Roman Dutch Law and the Judicature Act (on judicial powers) that the Courts are “upper guardians” of children under 18 years tasked with protecting their interests. “The best interests” concept therefore provides a core legal value in the area of child law which can be applied to prevent abuse and limit parental rights.

Since the law on parent and child is found mostly in non-statutory law, and in the ad hoc legislation cited above, until recently, there was no clear **statutory** provision which stated that parental responsibility must be exercised in the best interests of the child. **The ICCPR Act (2007) s.5 (2) now incorporates a general statement on the paramountcy to be given best interests of the child in relation to all matters concerning children, “whether undertaken by public or private social welfare organisations, courts, administrative authorities or legislative bodies.”** This can provide a basis for also limiting parental rights and imposing responsibilities.

The legal position on evolving capacity has been described earlier, and in 2.2. Evolving capacity and the views of a mature minor are considered by the courts in custody litigation sometimes. They must be considered in international child abduction proceedings and in foster care placements under the Tsunami legislation. As mentioned, the Courts have also specific responsibilities in this regard, and the participation of children is provided for in juvenile justice and adoption proceedings. However it is not clear whether these standards are followed with consistency in these proceedings, and there is no clear procedure for ascertaining the wishes of the child. We have referred to the anomalous provisions in the Human Tissue Transplant Act (1987) s.23 and s.8 giving overriding parental power regarding tissue donations up to the age of 21 years.

In the case of young persons, there is a parental duty of support until the age of 25 years that has been recognized in Maintenance Act (1999). Under the General Marriages Ordinance which applies to the

majority of Sri Lankans (not governed by personal law), parental consent is required for marriage up to the age of 21 years. This provision too is considered anomalous and carried over from the era when the age of majority was 21 years. However Courts can be moved to provide consent to marriage where parents refuse consent unreasonably.

The Policy document, the Children's Charter also states these principles.

Ref: (99)

Best interest of the child; Art .3

Responsibility of parent; Art.19

Parental Guidance and the Childs evolving capacities Art .5

There are in general no laws and regulations in this area, to encourage and support parents and guardians to understand their responsibilities and the need to respect the child's evolving capacities. However the statute of the National Child Protection Authority (NCPA) gives the agency the authority to undertake such programmes. The Tsunami Special Provisions Act reinforces the Authority's responsibilities in respect of children covered, which can extend to programmes of this nature. The legislation also makes willingness of parents to receive instruction on childcare and fostering, criteria in making decisions on granting care orders. Ad hoc programmes of support are conducted by NCPA and Foreign Employment Bureau but have not been reflected in policy formulations.

References: (100) (101) (102) (103) (104) (105)
(99) Article 25 and Art 12

The jurisprudence and statutes referred to earlier in discussing best interests and evolving capacity [sections 3.4.1. and 3.4.2] demonstrates that the child's rights in this regard and consideration of his/her views are recognized in legal principles.

We have already noted that Fundamental Rights actions on State violations of children's and young person's rights through administrative action are filed by adults in the Supreme Court on behalf of children through a guardian describe as a "next friend in the litigation or by young persons. Such cases can relate to the aspect of mental and physical health,

through the concept of the fundamental right to life, freedom from torture and degrading treatment, or a right to a pollution free environment, and access to education. It has been noted that there is no procedure to access the views of the child.

The procedure for issuing a foster care order in respect of a Tsunami affected child under 18 years or a Young Person under 21 years affected by the Tsunami makes provision for a Panel to consider the wishes of a child or young person, and a Magistrate's Court must obtain the consent of a child over 10 or a young person. Similarly as mentioned earlier, the consent of a child 10-14 years is a legal requirement under the Adoption Ordinance, and there are provisions to consult children in the law on juvenile justice. However as pointed out earlier, there are no specific procedures to ensure that the child's or young person's views are consulted, communicated and in fact receive consideration.

See earlier discussion on Fundamental rights Part I

2.4.4. Law and Policies on Access to Information in order to Express Views and Participate in Decision Making

The earlier discussion on the fundamental right to freedom of speech and expression indicate that there is a right to information by interpretation, even though it is not guaranteed. In giving paramountcy to the best interests of the child in court procedure and under the ICCPR Act, all agencies will also have an obligation to accommodate this right.

However as mentioned earlier, there are no guidelines to ensure that Courts follow this procedure. The single exception is under the Tsunami Special Revision Act (2005) where guidelines are given in the Statute. Even here, a procedure for ensuring the guidelines are followed is not defined. The NCPA has a poster campaign meant to reach children. We shall note later in discussing children's access to reproductive health information that policies on health are sometimes undermined by conservative attitudes in the education sector on the concept of participatory teaching and learning. This also undermines the legal rights of children and the concept of evolving capacity and respect for their views.

2.5. Informed Consent to Medical Treatment

There are no legal provisions specific to health. The normal legal provisions on age of discretion apply, and indicate that “evolving capacity” of the child must be accommodated, and that consent must be obtained in the case of a child above the “age of discretion” (14 / 16 years), and in the case of a child “mature enough to express consent.”

The Sri Lankan Civil law on damages is based on a combination of Roman Dutch Law and English law. Currently the doctrine of “informed consent” has not been accepted in English law – and there is a large area of “therapeutic privilege” not to disclose information. In some legal systems, such as South Africa, courts administering Roman Dutch Law have accepted the doctrine of informed consent. In Sri Lanka where the civil law is also derived from Roman Dutch law; there is no jurisprudence to indicate that the concept of informed consent has been accepted as part of our law.

However medical practitioners administer “consent” forms requiring written consent to adults and to parents in the case of children less than 18 years. There appears to be no awareness of the need to obtain “informed consent” in the case of children of an “age of discretion,” or of adequate maturity and understanding. Consent in the case of an adolescent is expressed by the parent, contravening the legal principles referred to above. (106)

There is clearly a conflict between the legal principles and medical practice since there is no clear legislative provision indicating that the “age of discretion” is reached by an adolescent at 16 years. Ethical guidelines of the Sri Lanka Medical Council suggest that if a person under 18 has “sufficient understanding and intelligence” they can demonstrate competence to make a medical decision. This reflects the discrepancy between law and medical practice.

The Draft Maternal and Child Policy 2008 a recently drafted policy statement of the Ministry of Health contains information that suggests that children and adolescents should make informed choices. However there is no reference to any procedure for obtaining this consent. The Draft Mental Health Act 2007 has some provisions which specifically cover

the area of consent by mental patients, and a procedure to ensure whether they have capacity to consent. A further provision indicates that “treatment shall not be given to a person with mental illness without his or her informed consent.” A procedure for making a determination is also included. It would seem that these provisions could serve as a model to be included in general health legislation that covers the issue of informed consent. This would be also an opportunity to incorporate the jurisprudence on the adolescent’s right to make autonomous decisions on reaching the age of 16 years.

2.6. Access to Information from a Diversity of Sources for Children’s Well Being and Health

The general provision on access to information in order to facilitate decision making discussed as an aspect of the evolving capacity are relevant here.

There are no specific laws dealing with access to information on health.

However some policy documents of the Health Ministry deal with this aspect. Sri Lanka’s success in the area of community health and its good health indicators for women and children have been a result of both its free education and communication policies. The Health Act, in as early as 1952 highlighted the duty of the State to “disseminate health information.”[Health Act (1952)S.] The Population and Reproductive Health Policy of 1998 also gives priority to publishing and disseminating updated information. However adolescents are not specifically referred to.

More recently, the Family Health Bureau has accepted on principle that women under 18 years access to oral contraceptive pills, and condoms. And the National Policy on Health of Young Persons currently being prepared prioritizes providing “access to information and services and creating an enabling environment.” A General Circular of 2007 [PA/DDG/PHS/IIE/12/2007 of 2.20.2007] provides for reproductive health care and services being given to pregnant women of any age, married or unmarried, or even if under 15 years if living together with a man. This reflects a flexible policy of providing services, but it is not clear that it is

matched with a similar policy of providing counselling and information through the health system.

Sri Lanka's country report at the Bangladesh Population Conference highlights the priority given in the Education policy to population education programmes in schools beginning in 1973. There is a reference to Family Life Education programmes in schools from 1990's. [Fifth Asian and Pacific Population Conference 11-17 Dec. 2002 Bangkok, Sri Lanka Country Report, Ministry of Health]

In 1993 a National Steering Committee on Adolescent Health was established, and a manual on RH published jointly by the Family Health Bureau and the Education Ministry. The School curriculum designed by the Government up to 2015 identified reproductive issues to be taught from Grade 6 onwards. However there is no information on contraception. The Health Master Plan and the National Health Policy also seek to provide information in these areas of RH to adolescents. There is a perception that there is reluctance on the part of education authorities to take these programmes on board, so as to incorporate them in the school curriculum. This issue seems to be perceived as culturally sensitive, and this has contributed to difficulties in implementing RH Programmes for adolescents and children in the education sector

The Population and Reproductive Health Policy (1998) emphasize use of mass media both electronic and print for public discussion of reproductive health issues. The Action Plan connected with this emphasizes using mass media to strengthen the family life education programmes in schools.

There is clearly a need for close co-ordination between the Health and Education Ministries to sustain a consistent approach to the issue of providing adolescents with RH messages and encourage responsible sexual behaviour. In Sri Lanka television is accessible throughout the country and in low income urban slum communities. Due to high literacy rates communication messages in print media are also accessible. These are important resources through which all children and adolescents can access RH messages. The ambivalence on RH issues in the education sector has

hampered the successful use of media to provide information on RH to children and adolescents.

2.7. Privacy and Confidentiality (107)

The CRC recognises a right of privacy in Art.16. This can be interpreted widely to link with many other rights. However the CRC language justifies a limited interpretation that covers privacy in the family home and correspondence, dignity and reputation. As mentioned earlier the right of privacy and confidentiality in regard to health is not guaranteed specifically in the Constitution. The Children's Charter (1993) recognizes a right of privacy (Art 16), but this is a policy statement, and has not been acted upon by successive governments. The civil law on Delict and protection of "dignity," and legal personality in the Constitution and the ICCPR Act may be used to recognize and argue for a child's right to privacy. There is no local case law directly in point.

The ICCPR Act, jurisprudence and the specific legislation mentioned recognize the norm of the child's welfare or best interests. The concept of "age of discretion" at 16 yrs and evolving capacity referred to earlier also suggests that medical and educational personnel can use the concept of "best interests" to respect the child's privacy dignity and reputation and correspondence and provide advice and counselling on health matters, irrespective of the wishes of the parent.

Even if it is agreed that a restricted right to confidentiality and privacy is recognised in law, in this sense, there is no method of enforcement to obtain or challenge a decision on the matter in the courts, or any other tribunal. Informal counselling can be given to parents and the child through the Child Protection Authority. In the event of HIV infection of child medical personnel may give the parents rather than an adolescent, the information on testing, counselling and treatment, since they are not aware of the concept of the age of discretion. Such an adolescent is considered as a minor child under 18 yrs and subject to parental authority.

In the case of children **under**16 years of age, the law on parental rights suggests that advice and counselling should be with parental consent. However if there is unreasonable parental refusal, there is no clear procedure to take this matter to the courts and obtain a decision. It

is not clear whether the Child Protection Authority has status to take a case to court challenging the parental decision, or inversely, for a parent to challenge the decision of a health or school authority to provide information (as in the Gillick Case in England). (Gillick v. West Norfolk Health Authority 1986 1 A.C.112)

Cultural values on parental authority and children's status do not encourage the recognition of 'privacy' rights in the case of young children. There could be resistance to recognizing the idea of privacy and confidentiality, especially in regard to what are considered as the sensitive area of sexuality and reproductive health. In reporting to the CRC Committee, Sri Lanka stated that the cultural context must determine the scope of a child's right to privacy. By contrast there may be a grudging concession that health and education authorities **can** act independently of parents in the case of adolescents above 14 years, or children who have reached higher secondary school age. There is jurisprudence that a girl of 15 years has a right to decide to leave the parental home, (in *Re Evelyn Warnakulasuriya* (1955) 56 NLR 525) and this is consistent with the law on custodial rights, where the law recognizes "an age of discretion or maturity" at which there is a diminishing of parental authority.

The research studies on the situation on children's homes both State and private suggest that protection is over-emphasized to the extent that participation rights of children are ignored. Consequently the rules of discipline and norms of conduct in institutions suggest that there is no space for children to express a viewpoint, or any right to privacy and confidentiality. This situation is also replicated in general in the secondary and primary school environment of State educational institutions for children. The situation could be different in private schools where there are some counselling programmes, which tend to give priority to children's participation, particularly at the middle and upper secondary school levels.

There are some legal provisions in the Penal Code and the Prevention of Domestic Violence 2005 that prohibit publication of proceedings on sexual offences or revealing the identity of applicants in and matters relating to domestic violence. These protections of privacy are available to children. Adolescents over 16 years can claim these protections on their own, with legal advice, on the basis of evolving

capacity and age of discretion, but children's interests below this age in this regard must be protected by parents and guardians. The Constitution provides in the Chapter on the Judiciary that courts and tribunals shall have public sittings, but gives the presiding judge, discretion to exclude "persons not directly interested in the proceedings" in "family relations" and "sexual matters". This can ensure that the privacy of children in sexual abuse and family cases can be ensured by closed proceedings held "in camera". Amendments to Evidence Ordinance introduced in 1999, provides for child friendly procedures for recording the evidence of children including accepting evidence without administering an oath, accepting a medical practitioner's statement of probable age and accepting video recording of the child's evidence.

Some aspects of Sri Lankan Law and policy is clearly not in harmony with the higher standards CRC and international human rights on privacy and confidentiality. However this is a difficult area for intervention due to the reasons mentioned earlier and parental rights in regard to children **under** the age of discretion. The issue is can a lower age threshold be set in regard to privacy issues or should the right to privacy of adolescents be linked to age of discretion on the ground that this is the age of evolving capacity

2.8. The Right of Access to Education

State resourced (free) health services and access to education from primary to tertiary levels have been accepted policies in Sri Lanka from the 1940s. When CRC was ratified the Children's Charter, introduced as a policy statement referred specifically to the State obligation to provide compulsory education from the age of 6-16 years (Art 28) However free education (i.e. non fee levying education) was provided in State schools for both boys and girls by post independence government as part of general policy, even in the absence of compulsory education regulations under the Education Ordinance of 1939. Consequently primary school education in State schools has been resourced by the State for many decades.

Over the years the admission process of the Ministry of Education has become highly competitive, particularly because of the pressure for admission to the highly rated national schools. There have been

allegations of and investigations on corruption in admission to State schools. In a recent case challenging denial of school admission as a violation of the right to equality of a child the Supreme Court reviewed the guidelines for admission and suggested that a new scheme should be developed for admission. The Ministry of Education modified the guidelines for admission (*Haputantrige v Sujatha Vidyalaya* Note.²⁶)

We have already noted that school admissions have become a fertile source for litigation. Cases filed on behalf of children from different economic and social backgrounds have challenged the admission system, alleging a violation of the right to equality guaranteed by the Constitution. The courts have intervened to give redress. However, many low income parents do not have the capacity to move the courts, and inequities surface in regard to access to primary schools managed by the State. The closure of schools in some remote areas has attracted recent controversy, with complaints that children are being denied access to schooling.

Sri Lanka introduced a compulsory education regulation and monitoring system from the nineteen thirties, and jurisprudence on child support imposed an obligation to provide educational opportunity. This contributed to high participation rates among boys and girls at the primary level. These were reinforced by the implementation of child labour laws that prohibited children from working during school hours. Policies on free school uniforms and text books and other measures supported these laws. These factors contributed to the lower incidence of child labour in Sri Lanka when compared to other countries in the region. It also laid the foundation for elimination of gender disparities in educational opportunities.

In the last decade, the failure to sustain this system, and a problem of children dropping out of school and being exploited in employment, led to the reintroduction of compulsory education regulations. No .1 of 1997 under the Education Ordinance (1939). Child Rights activist argued to make the upper age threshold 16 years. However the age specified is 14 years to conform with minimum age for child labour in legislation, though educationists and child rights activists have argued that the age should be 16 years (at upper secondary school). The Child Employment Laws were amended in 2003 to strengthen implementation

of the compulsory education regulations and retain children in the school system. However the problem of uneven resources and quality remain, and there is continuing concern that low income children are not benefiting adequately from the positive law and policy framework relating to primary school education.

The Maintenance Act 1999 s.2 emphasizes the parental obligation to provide maintenance and support for a child under 18 years, an adult child up to 25 years and a disabled adult child. This will be interpreted in the light of past jurisprudence to include education. Providing and education is referred to as an obligation of foster care in the Tsunami Act. (S.Goonesekere Law of Parent and Child 1987 **(59)** chapter 10 discusses jurisprudence)

It has been noted that the ICCPR Act 2007 now confers citizens with a right to basic services provided to the public by the State. If this provision applies to children it is a statutory reaffirmation of the right to education since education may be consider in Sri Lanka as a basic service provided to the public by the state.

Access to secondary and tertiary education is not regulated by law but by policies on free and universal access to education at both these levels. The ICCPR Act provision can be interpreted as a statutory recognition of this right.

Tertiary university education has been and continues to be, provided exclusively through the State sponsored “free” education systems. Thus the Universities Act (1978) prevents the setting up of private institutions, and regulates degree and diploma awarding tertiary education institutions. A few fee levying private institutions have been authorized to conduct programmes and award diplomas and degrees, through academic linkages to foreign tertiary education institutions. There are no similar restrictions on private secondary school institutions.

Since there are very few State institutions, there is enormous pressure for admission, and a large student population is left out of tertiary education institutions. Thus though the law provides access, opportunities are in fact very restricted. Mushrooming and unregulated

private institutions which provide short tertiary education courses, or diplomas and degrees from foreign universities with off-campus teaching arrangements, are available to students who can afford to pay fees. These institutions are not officially recognized but operate as “foreign investment projects” outside the State regulated system. They are popular with students and parents who can afford to pay fees, but criticized by educationists for lack of quality control and failure to conform to professional standards. However they continue to remain unregulated and accepted as a response to the restrictions of the State system.

The Maintenance Act and the Tsunami Act reiterate obligations to provide education (up to 18 or 25 years) or up to 18 or 21 years, in the case of foster care of tsunami affected children and young persons.

There have been consistent efforts in law and policy to ensure that children have access to State schools. However there is continued problem of school dropouts in some low income families’ particularly in rural and plantation areas and in communities in conflict affected areas in the North and East.

2.9. Maximum Use of Available Resources – National Financing of Health Care

As pointed out earlier, education is not referred to as a fundamental right in the Constitution but is recognized in the Directive Principles of State Policy outlined in the Constitution. Curiously there is no reference to Health in either of these parts of the Constitution. However we have argued that the jurisprudence on the right to education and the right to life now suggest that there is also a right to National resource for basic needs in health care. The recent ICCPR Act 2007 confirms this in a specific provision that we have already referred to. It has been pointed out that Art 6 (b) of this Act gives every citizen a right and opportunity to have access to services provided to the public by the State. An enforcement procedure is also provided by an application in the High Court. We have also referred to the fact that long before laws and Constitutional provisions were interpreted as covering this area, the State in fact provided resources for a State system of health care. The legal procedures have therefore reinforced what had already been accepted in policy formulation and resource allocation. The critical problem today is the

maintenance of adequate levels of State financing in the health sector when the defence budget has increased dramatically and there are many other demands on the national budget. In addition aid provided to Sri Lanka has also been reduced on because of the fact Sri Lanka has improved health indicators from its original status. In this environment clearly allocation for RH services for adolescents has also become a problem.

PART 3

Early childbearing, maternal mortality and morbidity among adolescents

Early childbearing, maternal mortality and morbidity among adolescents

Family planning

Eliminating Unsafe Abortion

Combating STIs including HIV

Promoting sexual health, addressing sexual violence, FGM and other harmful practices

3.1. Early childbearing, maternal mortality and morbidity among adolescents

3.1.1. Health situation

3.1.1.1. Age specific fertility rate

Fertility rates have come down gradually over the years in Sri Lanka and presently the last published value is 1.9¹²⁰

However preliminary data released recently by the Dept of Censes and Statistics after DHSS 2006/7 showed a marginal reversal of this trend with the TFR reaching 2.4

The age specific fertility rate for women of a given age / age group is defined as the number of babies born to women of that age / age group, per 1000 women of that age / age group I the population at the middle of that year.

The age specific fertility rates among adolescents are shown below and it shows a downward trend.

Table 04: Age specific fertility rates (per 1000 women)

Age Group (yrs)	Age Specific Fertility Rates (Per 1000 women)					
	1963	1974	1981	1982-1987	1998-1993	1995-2000
15-19	52	31	34	38	35	27
20-24	228	146	172	147	110	83
25-29	278	161	222	161	134	118
30-34	240	158	177	122	104	98
35-39	157	126	99	71	54	40
40-44	46	43	37	23	14	8
45-49	7	6	0	3	4	1
TFR	5	3.4	3.7	2.8	2.3	1.9

Source: (130)

3.1.1.2. Prevalence of Adolescent Pregnancies

Although the legal age of marriage in Sri Lanka is 18 years, evidence shows that sexual activity among adolescents is not uncommon **(112)** The Registrar General Department has recorded a large number of deliveries to mothers less than 18 yrs of age. Of them, a considerable number of mothers have been under the age of 16 yrs which is the minimum age of giving consent for sexual intercourse (unless they were all married under the Muslim law which is unlikely considering the population ratios)

Under the existing criminal law set out in te Penal Code, a person who fathers a baby to a girl less than 16 yrs is liable to be prosecuted as having committed statutory rape. They sometimes face this predicament because the health authorities are obliged to report this fact at the confinement of the girl below the age of 16 years.

Such reporting by the health care providers has led to lack of trust of the mothers and the community leading to difficulties in providing care to this high risk group of teenage mothers. On request of the Ministry of Health the Attorney General has issued a letter to Inspector General of Police with legal clarification , relieving the health care providers both in the field and in the hospitals from reporting such instances to the Police or legal authorities. (General Circular letter No.02.29/2011 of DGHS)

Table 02: Age specific deliveries 1996-2003

Mothers Age at Delivery	1996	1997	1998	1999	2000	2001	2002	2003
12	15	01	02	00	00	02	00	00
13	19	19	26	25	10	22	24	34
14	105	99	117	127	117	96	151	127
15	641	575	615	566	576	564	508	584
16	2303	2203	1874	1939	1917	1974	1729	1689
17	4643	5172	4729	4291	4459	4503	4341	3906
18	9279	8651	9073	9208	8929	8940	8386	8242
Total	17005	16720	16436	16156	16008	16101	15139	14582

Source: Registrar General Department **(113)**

It is well known that these adolescent pregnancies carry an increased health risk. There is no national data on maternal morbidity of adolescents but there are well documented studies that maternal morbidity among adolescents is high. Adolescents often report their pregnancies later than adult women.¹¹⁴ They are more likely to suffer with eclampsia and obstructed labor and its complications, compared with women who are pregnant in their early twenties.¹¹⁵ The situation of MMR of adolescents is addressed later on in the report

Provision to have a polygamous marriage is available in Sri Lanka only under the Muslim personal Law. This issue is compounded by the fact that there is no minimum age of marriage specified in Muslim personal laws. As data on marriages conducted under the Muslim law is not available, it is difficult to quantify the incidence of adolescent pregnancies due to this provision.

3.1.1.3. System of Delivering Maternity Care

Viable Primary Care Infrastructure supported by a wide network of health institutions has been crucial to the success of maternity and child care services in Sri Lanka. An important factor in achieving this combination is the utilization of health professionals in the decision making positions.

Under the Central Ministry of Health / Dept of Health, the Deputy Director General of Public Health Services (DDGPHS) is in charge of policy, monitoring, training and some resource allocations with respect to maternity, adolescent and child care. The Director in charge of Youth, Elderly and Disabled too functions under the same (DDGPHS). The Family Health Bureau (FHB) under the DDGPHS is the focal point for maternity and child-care.¹⁰⁸ These two Directors could network under this system easily

Under the provincial government system the Provincial Ministry of Health supplements maternity and child care independently. The provincial health services are managed by a Provincial Director of Health Services (PDHS) and there are Deputy Provincial Directors (DPDHS) who would have several Deputy Directors of health services (DDHS), formerly called Medical Officers of Health (MOH) delivering services to the public.

Each DDHS is expected to look after a population of 60,000 assisted by grass root level health workers including the Public Health Midwife (PHM)) who will provide maternity and child care services for a population of 3000-5000 people including the delivery of information and services on contraception.

One of the unique features of Sri Lankan Health system is the maintenance of an eligible couple's register which contains all married couples by the PHM who would provide contraceptive and other RH service and information. This is in addition to other primary health care duties inclusive of postnatal care of both mother and child.

Field care service provided through PHM and DDGPHS is backed up with a network of state run 514 hospitals spread throughout the country and staffed by medical officers or consultant obstetricians. There are around 80 specialist staffed units providing comprehensive obstetric care services including cesarean sections and blood transfusions.

At present nearly 96% of deliveries take place in health institutions of which 90% are in State run hospitals. Of those delivering in State hospitals nearly 70% deliver in specialist staffed hospitals. Even in the rural areas 96% of the deliveries were in government hospitals, and only 0.8% of the deliveries were at home. In the urban areas including Colombo more than 75% of deliveries were in government hospitals, while the rest were in private hospitals.¹⁰⁸

Private health care contributes only to about 10% of the deliveries but provides antenatal care by way of consultations through the general practitioners and the specialist obstetricians who provide this service after official working hours

Presently the MMR stands at 38 per 100,000¹⁰⁹ and is an achievement for a country with a per capita gross national income of US\$ 1200 with one third of the population below the poverty line. The model of antenatal clinic visits currently practiced is the traditional ANC model, i.e. once a month in the first 28 weeks thereafter fortnightly during 28-36 weeks and weekly for next four weeks.

In addition regular home visits are done by the public health midwives.

A recently conducted External Review on Maternal and New Born Care¹¹⁰ commented: “Field visit information suggests that pregnant women are simultaneously accessing services at multiple settings (i.e. field clinics, hospital clinic, and some even through visits to an obstetrician in the private sector)”

Data presented at the Siva Cinnathamby Oration of the Sri Lanka College of Obstetrician and Gynecologist provided the following information in 2004¹¹¹

Table 01: Field and Institutional clinic visits Sri Lanka 2004

Deliveries	363549
Booking visits MOH Clinics	331339
2nd visits MOH Clinics	1735978
Hospital Clinics	518349
Total visits	2067317
National Average	6.4 visits

Source: (111)

3.1.1.4. Testing pregnant mother for HIV, other STDs and Hemoglobin

Sri Lanka is a low prevalence country for HIV with an estimated prevalence of less than 0.1% in 2007¹¹⁶

Routine Antenatal care package does not include mandatory HIV testing but counseling and voluntary testing is available in some state health institutions. Informed Consent is mandatory for testing blood for HIV and the spouse is not informed of the result without the explicit consent of the patient, although counseling usually results in patients recognizing their responsibility to her partner.

Since there is lack of awareness of 16 years as the age of discretion or principle of evolving capacity, in practice those under 18 years are not

considered capable of giving consent and the parent or guardian needs to give the consent or authority for testing blood for HIV.

However a “married” young person could give the consent for testing the blood for HIV. Medical guidelines refer to the right of a married adolescent to give consent, and do not reflect the raised age of marriage to 18 years¹¹⁷

Routine ANC package includes testing for VDRL (for syphilis) and the test is offered in hospital and most of the field clinics free of charge.¹¹⁸ Information on Antenatal care provided by public health mid wives showed that in 2004 64.5% pregnant women of all ages and in 2005, 66.5% women and in 2006, 68.7%¹¹⁹ women of all ages had testing for VDRL done. .

Although formal consent is not needed for testing for VDRL, the patient may refuse to be tested if she wishes so.

The routine ANC package includes testing blood for hemoglobin and adolescents are provided the same facility.

In the year 2006 there were 385205 pregnant mothers registered and only 68553 were tested through the field care system. This gives a percentage 17.8% (FHB) but many more of them may have got it done through the hospitals and the private sector laboratories.

3.1.1.5. Maternity care provision to Adolescents

Although information regarding antenatal care is collected by the state institutions, national age disaggregated data to identify details of maternity care provision to adolescents is not available. Although some isolated studies regarding adolescent pregnancies are available it is difficult to extrapolate them to a national level.

Adolescents are not discriminated when receiving maternity care and are entitled to the state maternity care package. However the unmarried adolescent pregnant girls may delay entry into the ANC programme due to stigma attached to pregnancies out of wed lock and the reluctance to use these services.

3.1.1.6. Births attended by skilled personnel

A Trained birth attendant is available in nearly 98% of deliveries. In all the state health institutions a nursing officer and / or midwife will attend the delivery with a MBBS qualified doctor available on call for emergencies. In some of the teaching and general hospitals a doctor dedicated to the labor room care is available.

It was interesting to observe 50%-58% of the deliveries in the urban sector were by doctors, while it was 38% and 44% in the rural and estate sectors respectively.¹²⁰

In the private sector it is attended mostly by the specialist obstetrician though occasionally medical officers may undertake the delivery.

The chart indicates that over the years the percentage of doctors doing the delivery has increased in relation to those done by nurses and midwives.

The pattern of assistance at delivery is the same for the adolescents and older pregnant mothers and no discrimination on adolescents is noticed.

Mother's age at birth	Doctor			Govt. Nurse/Midwife			Other		
	1987 (%)	1993 (%)	2000 (%)	1987 (%)	1993 (%)	2000 (%)	1987 (%)	1993 (%)	2000 (%)
<20	12	18.7	31.4	80.5	74.5	64.2	7.5	6.8	4.5
20-34	15.6	23.7	41.4	79.7	70.5	54.6	4.7	5.8	3.9
35+		26.1	53.7		68.5	43.0		5.4	3.3

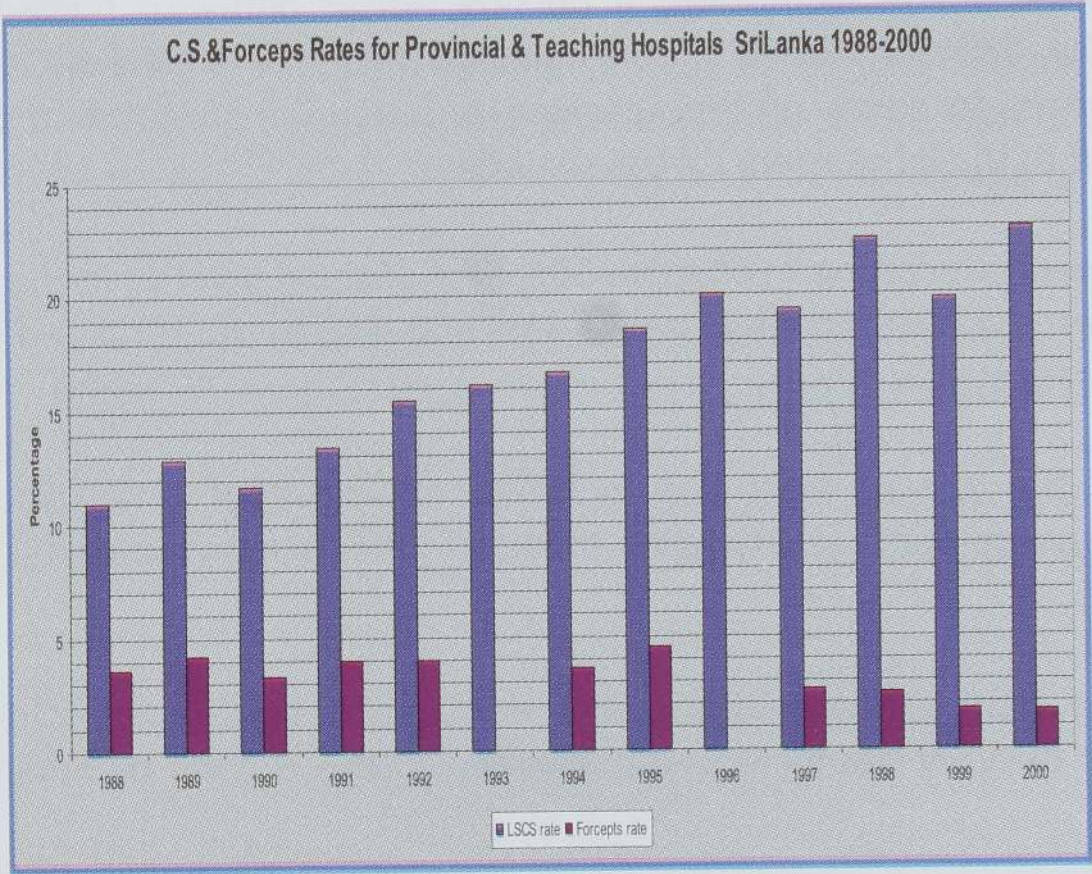
Table 03: Skilled attendance at delivery
Source: (120,121,122)

3.1.1.7. Caesarean Section as a proportion of all births

There has been a gradual but steady increase in the Caesarean Section rates resulting in doubling the rate between 1988 and 2000.¹²⁵

Unfortunately age disaggregated data is not available to comment on the CS rate among adolescents

Fig: 01: CS and forceps rates for provincial and teaching hospitals Sri Lanka 1988-2000



Source: (125)

The National Caesarian Section Rates are at the upper recommended rates by the WHO and stands at 15.4 in 2001¹²⁶, but individual hospitals, particularly the tertiary care institutions report much higher values 22.3%. In addition presently there is request for by the patients for C.S deliveries even when it is not indicated medically.

- Teaching hospital 22.3%
- Maternity Hospital 19.8%
- Provincial Hospital 16.7%
- Base Hospital 10.5%
- District Hospital 0.1%
- Overall 11.4% (1999)

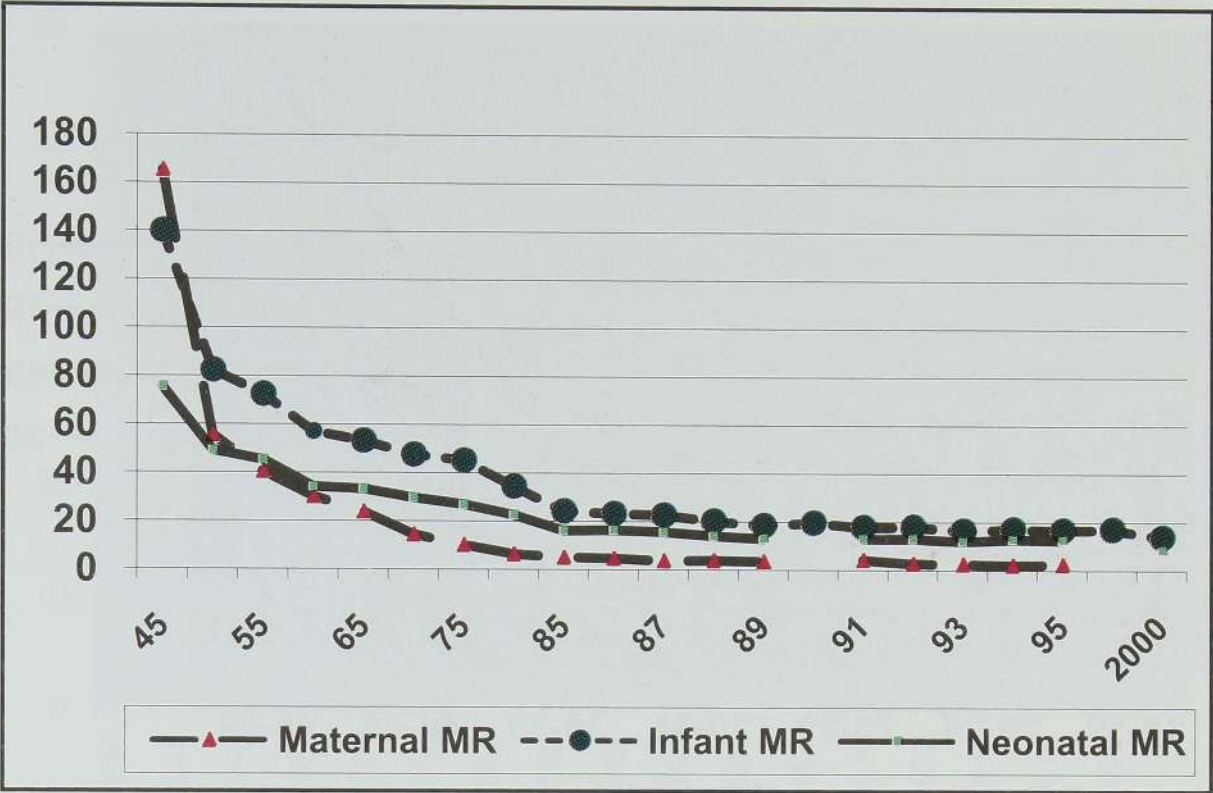
Ref– (127)

3.1.1.8. Maternal Mortality Ratio

Sri Lanka has relatively good health indices since getting Independence. Maternal Mortality rate is: 38 per 100,000 live births¹⁰⁹, infant mortality rate is 13.6 and the neonatal mortality rate is 8.3 for 2000.

These indicators can be considered as extremely favorable for a developing Country such as Sri Lanka.¹¹⁴

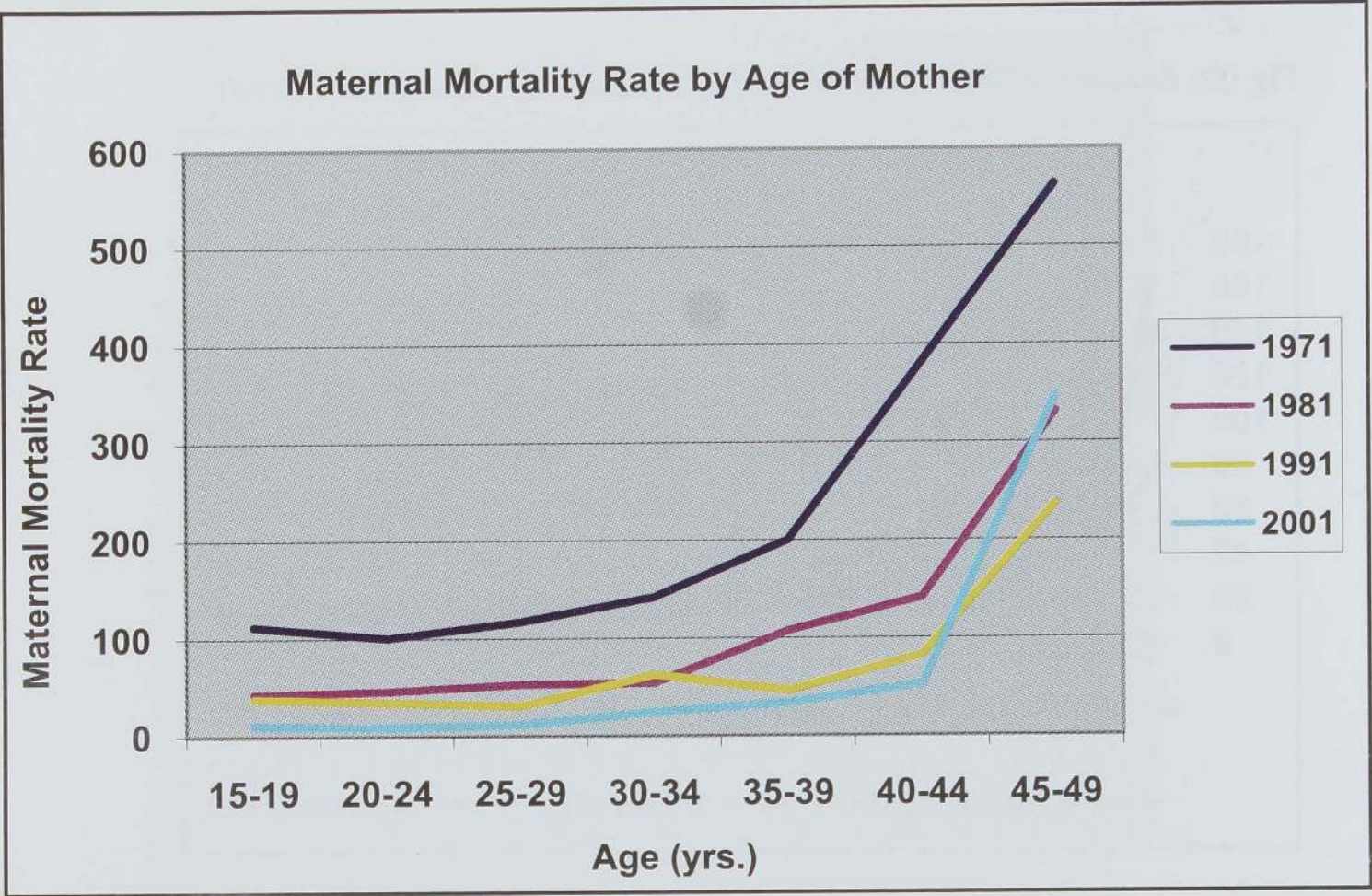
Fig 02: Maternal, infant and neonatal mortality ratios 1945-2000



Source: (109)

Usually the Maternal Mortality Rates for adolescents are expected to be higher than the rest of the pregnant population. However available age specific MMR does not show a clear pattern indicating a higher risk. This paradoxical finding is possibly because of the small number of maternal deaths taking place in Sri Lanka and should not be used to make concrete conclusions.

Fig: 03: Age specific maternal mortality rates 1971 -2001



Source: (113), (128)

3.1.1.9. Perinatal Mortality and live Births with low birth Weight

Information on perinatal mortality across the country is not available because Stillbirths are not recorded in some hospitals. Even where available age disaggregated data is not available.

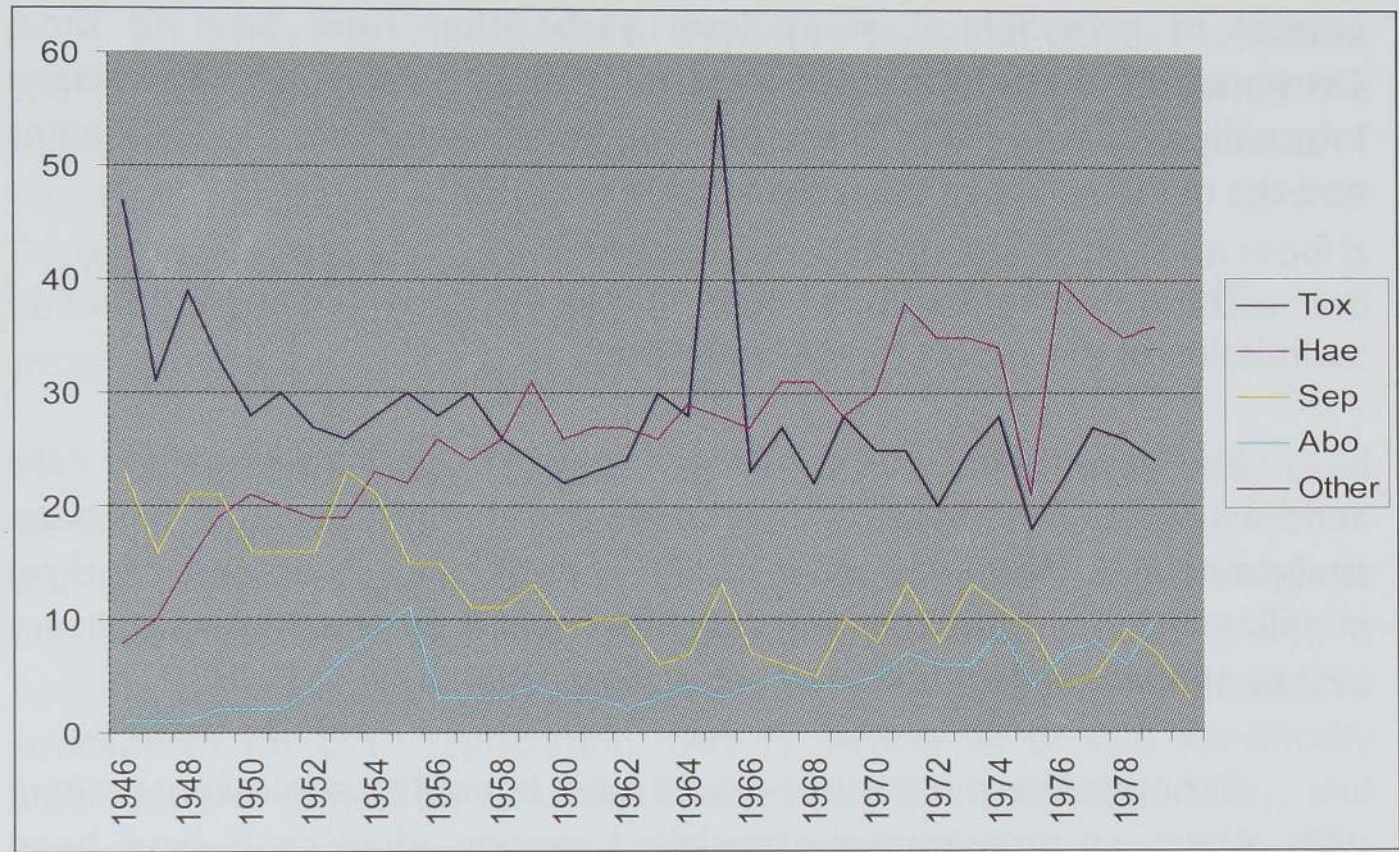
Age specific low birth with weight births are not available but the overall rate for low birth weight deliveries is 11.7 in 2004 and 11.5 in 2005 as reported by the field care personnel respectively¹⁰⁹

3.1.1.10. Causal trends of Maternal Deaths

Unfortunately causes of maternal deaths specific for adolescents are not available.

The commonest cause of maternal death considering all ages, remains as PPH over the years with Hypertensive disorders as the second commonest .The changing causal trend is seen in the chart.

Fig 04: Causal trends of Maternal Deaths



(129)

3.1.1.11. Maternity Care in Natural disaster situations

Under crisis situations such as the Tsunami the breakdown of the system takes place as seen in the 2004 Tsunami

An assessment of reproductive health services in Tsunami affected districts of Sri Lanka conducted in 2005 by UNFPA, FHB and MoH concluded “Antenatal, Nataland post-natal care given to mothers lack in quantity and quality due to the inherent shortage of human resources; Both in the field and the institutions. This is further aggravated by the inaccessibility to services within a reasonable distance. Births conducted by unskilled attendants do occur in some districts. In the Galle District in the Southern province an emergency field hospital was set up with the help of donors to cater specifically to pregnant mothers and deliveries, since the main maternity hospital was destroyed by the tsunami.

No studies or information on the services specifically on adolescents in disaster situation are available.

3.1.1.12. Health Care in Conflict areas and internally displaced camps

From the beginning of the internal armed conflict in the late seventies, the areas controlled by the government and the LTTE, have been in a volatile situation with each party to the conflict taking over control of geographical areas from each other from time to time. Consequently there have been large number of persons who have been internally displaced (IDP). These persons have been located in IDP Camps and the numbers have been changing in magnitude.

The statement below is based on information available as of date of submission of this report (end March 2009).

The government has constantly strived to provide maternity care services. Most of the Medical Institutions and the Infrastructure has been maintained. A WHO report in 2007¹²³ confirmed that the medical supplies including vaccines are adequate, while the healthcare delivery system though present is spread out disproportionately.

Although these measures would have benefited adolescents, along with others, no programmes especially targeting adolescents have been conducted by the state

According to MoH sources about 33,000 IDPs were being looked after in Vauniya alone around the first week of March 2009. Unfortunately the number of adolescents within this group is not available¹²⁴

The Government of Sri Lanka and NGOs such as WHO ,UNFPA, Red Cross and MSF plays a major role in the delivery of health care including mobile services.

The MoH has provided reproductive health needs such as antenatal care, provision of sanitary pads and contraceptives including Emergency contraception and condoms.¹²⁴

The supply of health delivery has been the main focus, while data on specific issues on reproductive health has been lacking. Detailed Data regarding IDPs inclusive of adolescents is difficult to access.

3.1.2. International and National human rights standards

3.1.2.1. International Human Rights Standards.

Sri Lanka has undertaken to introduce laws and policies to realize the human rights of children and adolescents by ratification of all the major human rights instruments that deal with these rights. Committees of experts appointed under these treaties pronounce General Recommendations and Comments and concluding observations on reports submitted by the country. These must also guide law, policies and programmes, and can be accessed on the web.

Sri Lanka has an obligation to prevent and eliminate early child bearing under the treaty standards of the CRC which recognizes the child and adolescent's right to life, to survival, to development and the highest attainable standard of health, without discrimination [Art 2, 6, 24]. A specific provision deals with the State's obligation to provide accessible procedures for birth registration. (Art 7). Article 24 of CRC specifically refers to the obligation to diminish child and adolescent mortality, and ensure appropriate pre-natal and post-natal care for mothers. This provision covers adolescent girls as children, as well as adolescent girl children who are mothers. Art. 24(3) Places an obligation on the State to "Take effective and appropriate measures to abolish traditional practices prejudicial to health."

The right to life and protection of children is recognized in ICCPR Art 6 and 24. The ICESCR recognizes the right of all children and young person's to special measures of protection and assistance and special assistance to mothers during a reasonable period before and after child birth. [Art 1, 2 & 3] ICESCR also reiterates the right of everyone to the highest attainable standard of physical and mental health, and reduction of still birth and infant mortality rate [Art 12]. CERD also recognizes a right to public health care (Art 5 (e) (4)).

CEDAW states that child betrothal and marriage shall have no legal effect and there should be a minimum age of marriage and a system of compulsory registration of marriage. [Art 16(2)]. Art 5 reinforces CRC Art 24(3). It places an obligation on the State to modify social and cultural patterns of conduct and eliminate customary and other practices that

conflict with the standards of gender equality. The CEDAW Committee has expanded on these norms by requiring non-discriminatory minimum ages of marriage and registration in General Recommendation (GR) 21 on Equality in Marriage, and by setting norms against early marriage in (GR) 24 on health of women and girls.

These norms on child marriage are reinforced in CRC's general provisions referred to above, and Art 24 (3) in particular even though there is no corresponding standard specifically prohibiting early marriage. However General Comments on Adolescent Health and HIV/AIDS of the CRC Committee have clarified that State Parties have an obligation to prevent early marriage, setting minimum ages for sexual consent and marriage and for medical treatment without consent. Early marriage is also recognized as a harmful traditional practice that must be eliminated. [CRC General Comment No.4 / 2003 on Adolescent Health, paras 9, 20]. CRC's General Comment No 3 on HIV/AIDS interprets Art 6 on the right to life as including the girl child's right to be protected from the practice of early marriage and forced marriage which are harmful and make her more vulnerable to HIV/AIDS.[General Comment No 3/ 2003 para 11]. There is no reference to forced marriage in either the Convention or the General Comment on Adolescent Health, and no reference to early marriage or forced marriage in the General Comment on Early Childhood [No 7/ 2005.] Nevertheless the specific reference to forced marriage in the General Comment on HIV and the other references to early marriage may now be considered to bring both practices within the norm of harmful practices prejudicial to children's rights.

CRC has many articles which confer a right to protection from violence and abuse. [Art 34 (sexual exploitation), Art. 37 (a) (torture and cruel inhuman treatment, Art 39 (victim support)]. These standards are also relevant in situations where harmful traditional practices such as female circumcision and acts of violence can result in maternal death or morbidity among adolescents or early child bearing. CRC's overriding norm of the 'Best Interests of the Child (Art 3) and maximum use of available resources for health and education (Art 4) are also important. CEDAW's GR 24 on health, GR 19 on VAW and GR 21 on Equality in Marriage include references to early forced marriage and female circumcision as harmful traditional practices that must be eliminated. They strengthen the

standards set by Art 5 on modifying harmful customary and traditional practices.

ICCPR and CAT which have been ratified by Sri Lanka also recognize the right to freedom from torture and inhuman degrading treatment. [ICCPR Art 7, CAT Art. 1, 16]. CERD recognizes a right to security of person and protection from violence [Art 5 (b)]. Though the State connection is emphasized in Art 1 and 16 of CAT, over the years international law as interpreted by the CAT Committee, the CEDAW Committee in General Recommendation 19 and decisions on the Optional Protocol, recognize that private acts could be included if there is State inaction or acquiescence. Consequently domestic violence female circumcision, and forced marriage can also be considered to constitute torture or inhuman degrading treatment. The State has an obligation to prevent such practices.

Article 30 of CRC and Art 27 of ICCPR recognize the right of a child or adolescent from a minority ethnic or religious community to enjoy his/her culture and profess or practice her/her religion. However these rights can be considered qualified by the other rights discussed. This has been made clear in particular by Art 24 (3) of CRC which places an obligation to abolish traditional practices prejudicial to health, while Art 2 of CRC and Art 26 of ICCPR and CERD Art 5 set a norm of non discrimination which is relevant for all children. These standards have been reinforced by CEDAW and prohibit in particular discrimination against unwed mothers and non-marital children and girl children. States Parties have an obligation under that CEDAW to modify social and cultural patterns that foster discrimination against women.

ICESCR and CRC have standards on health for working children which confirm that adolescents who are above the minimum age for employment should receive health care benefits in pregnancy. [CRC Art 32. ICESCR Art 7 (b) to (3)].

Even when marriage of adolescents is legal in Muslim personal law because the CEDAW prohibition on child marriage has not been enacted into law, CEDAW as well as other Conventions that Sri Lanka has ratified set norms on marriage which challenge the concept of legal child

marriages. There must be equal rights of spouses in marriage, and free consent to marry. Besides, married and unmarried parents must have the same rights regarding children, according to CEDAW. These rights must be exercised in the best interests of the child, giving that dimension “paramount or primordial” consideration. ICCPR Art 23 (3), CERD Art 5 (d)(iv) confirm these standards of equality between spouses and unmarried parents subject to the child’s best interests. [Art 16 (1) (d), art 5(b)].

The prohibition on forced and early marriage in international human rights standards in the above instruments is complemented by CRC’s recognition of every child’s right to education without discrimination. CEDAW has articles which require equal access to education for boys and girls, preventing girls dropping out of school for any reason, including pregnancy, and programmes for girls who have dropped out of school. [CRC Art 28, 29 (1)(d) 2; CEDAW Art 10 (c) 10 (f)]. CEDAW also imposes a commitment to revise school curricula and eliminate stereotypical attitudes to girls that can lead to discrimination. [Art 10 (c) Art 5]. CRC has a complementary standard. [Art 28 (1)(d)].

CEDAW has other standards which are relevant for early child bearing. Art 5(b) and 4(2) emphasizes the importance of protecting maternity as a “social function.” This Convention also has many provisions on protecting health and safety in work including safeguards on reproductive health which can be relevant for adolescent working girls above the minimum age of employment. There can be no dismissals because of maternity or discrimination against working mothers on the ground of maternity or pregnancy. These standards can be relevant in regard to providing equal access to continuing education, even if these girls have left school at the age when they become workers. There is also provision for maternity leave as a right. (CEDAW Art 11 (1) (f); 11 (2) (a) (b) (d))). These provisions are reinforced by the CEDAW Articles on health which specifically refer to right to services including nutrition in pregnancy and during lactation. [Art 12 (2)]. These human rights standards have been endorsed in CEDAW General Recommendation No 24 on Health which adopts a life cycle approach and elaborates on health standards of both women and girls. CEDAW GR 19 and 9 (1989) refer to sex disaggregated

data as an important dimension of implementing these human rights norms.

These standards are also endorsed by General Comments of the CRC Committee. CRC General Comment No 3 on HIV/AIDS refers to the need for adolescent sensitive health services, non-discrimination, respect for the right of privacy as recognized by Art 16 of the Convention, counseling depending on evolving capacity, and informed consent. All these aspects are relevant for early child bearing, maternal mortality and morbidity. CRC General Comment No 4 on Adolescent Health deals with non-discrimination, informed consent depending on evolving capacity, respect for privacy and confidentiality, access to RH information irrespective of parental consent, sexual and reproductive health services including abortion where it is not illegal, and support for adolescent parenthood.

It is therefore clear that Sri Lanka has undertaken commitments under these treaties which require the country to take steps to prohibit child marriage, and reduce and eliminate early child bearing, and maternal mortality and morbidity among adolescents. It is in this context that several concluding observations of treaty bodies have expressed concern that programmes have been commendable, but need to be improved to fulfill the commitments.

The CEDAW Committee has referred to “men and women’s equal access to family planning and the well developed maternal and child care system which has contributed to the declining maternal mortality. However the committee also refers to the incidence of domestic violence. The CRC Committee also refers to intra family violence and the absence of an organized system of counseling and reproductive health services for adolescents. Discrimination in regard to marriage and age of capacity to marry, have been referred to by the Human Rights Committee, the ICESCR Committee and the CEDAW Committee and are now relevant only in regard to the Muslim community. Malnutrition of women and children has been referred to by ICESCR Committee, the CEDAW Committee and regarding children by the CRC Committee. The CRC Committee has also referred to discrimination against children with disabilities and especially

girls. This Committee has expressed concern on the declining resources for health.

3.1.2.2. National Human Rights Standards

Details of national human rights standards have been included in part I of the report. Some of the provisions of Sri Lanka's Constitution (1978) recognize the international standards on this topic.

Sri Lanka's Constitution as mentioned earlier, does not guarantee a right to health as a social economic right for anyone. However we have noted that Sri Lanka has in fact provided and resourced free health for the population for many decades as an important and entrenched aspect of its social policies and political commitments. This has led to the provisions of services for hospital deliveries and pre and post natal care, even among the sections of the population categorized as urban and rural poor. More recently the Supreme Court has interpreted the Constitutional right to equality to encompass a right of access to education. An Article on the right to freedom from torture has been interpreted as recognizing a right to life. [See jurisprudence supra]. This jurisprudence may therefore be relevant to argue that the Constitution guarantees a child's right to survival and health care. The recent ICCPR Act 2007 S 6 (1) (b) gives every citizen a right to access basic services provided by the State. This provision can also be used to argue that there is a legal right to access health care.

As mentioned earlier, Sri Lanka introduced free education policies from the 1940s at all levels. This has accounted for acknowledged successes in preventing early marriage, the high social indicators on education, and high rates of school participation among boys and girls. [Early Child Marriage Child Spouses, Innocenti Digest no.7 March 2001 UNICEF Innocenti Research Centre Florence p 15: S Jayaweera Country Gender Assessment Sri Lanka Asian Development Bank Colombo 2004] These policies are also reflected in legal standards. In 1997 a Compulsory Education Regulation was introduced requiring all children between 5-14 to have access to schools. Supreme Court decisions on the right of non-discriminatory access to education referred to earlier, as an aspect of the right to equality have confirmed education as a justiciable right, even though it is not specified in the Constitution's Chapter on Fundamental Rights. The right of access to basic services provided by the State in the

ICCPR Act (2007) has confirmed the legal right to education. Consequently pregnancy cannot be used to deny access to a State school. Such a decision may be challenged in the Supreme Court for violation of fundamental rights, or the High Court under the ICCPR Act 2007. [Art 5, best interests, and protection from abuse].

We have noted that the Constitutional provision of the right to freedom of speech and expression in Art 14 (1) has been interpreted by the Supreme Court as conferring the right to obtain or receive information. This legal right can be considered relevant for giving access to RH information.

The family has been recognized in the Constitution Directive Principles of State Policy as the basic unit of society, entitled to protection. [Art 27]. However the Constitution recognizes in a Directive Principle of State Policy that the State shall promote with special care the interests of children and youth so as to ensure their full development. [Art 27 (13)] The Constitution also guarantees equality and non-discrimination on the ground of race, religion, language, caste, sex or place of birth. [Art (12 2)]. We have noted that there is provision for special measures to realize the rights of women, children and the disabled. {Art 12 (4)} These articles and provisions reinforced by the ICCPR Act's statement on children's rights [see supra], clarify that early and forced marriage are an infringement of child rights.

Consent to marry has been an important requirement of marriage under marriage legislation in Sri Lanka for over a century. [Early marriage legislation, Kandyan Marriage and Divorce Act (1951), and General Marriages Ordinance (1907)]. This legislation was amended in 1995 to raise the minimum age of marriage, and harmonise it with the age of majority at 18 years. This amendment reinforced the national standards prohibiting forced marriage, and harmonizes Sri Lankan national law with CEDAW and other international standards. The legislation has been reinforced by the ICCPR Act 2007 which recognizes the child's right to identity [Art 2].

Sri Lanka has had a well established system of registration of births and marriages, which combined with the education policies, have

impacted to virtually eliminate the incidence of early and forced marriage. Jurisprudence in the Courts from early times and even recently confirm that marriages below the minimum age are void and of no effect even with parental consent. The Muslim Personal Law by contrast does not set a minimum age, and permits forced marriage through the concept of marriage guardianship. This personal law clearly conflicts with international and national human rights standards. [Registration of Births and Deaths Act 1951: UNICEF Report supra: Gender Ethnicity and Religion Part I supra:] Non Muslim under age marriages are void and have no legal consequences in Sri Lanka according to jurisprudence in the courts- [Thiagaraja v Kurakkal] (1923) 25 NLR 89, Gunaratnam v Attorney General (2002) 2 Sri LR 202]

The Constitutional guarantee on prohibition of torture and inhuman degrading treatment and the right to equality and non-discrimination make harmful traditional practices such as early forced marriage and female circumcision, a violation of both the right to non-discrimination and bodily integrity and life. [Art 11, 12] These rights have been reinforced by the ICCPR Act 2007 provision on the child's right to protection from abuse [S.5]

The norm of equality and non-discrimination can be undermined by the right to freedom of conscience and religion (Art 10) and the right to culture (Art 14). We have noted that the manifestation of culture and religion in practice can be limited in the public interest. Sri Lanka's prolonged internal armed conflict and ethnic politics has prevented successive governments acquiring the political will to modify Muslim personal law.

National human rights standards harmonize with international law and in general prohibits discrimination against unmarried mothers or non-marital children, and set standards on health for pregnant adolescents, who are legally employed in the formal sector. An unmarried adolescent woman over the age of 14 years working in the public or private sector in manual or white collar work is entitled to 3-4 months statutory maternity leave. Unmarried adolescents would also have the same access as others to health and education according to the principles of Constitutional law and education law. All fathers and mothers have a duty to support minor

children according to Sri Lanka's law on family support. [Maintenance Act 1999 – Child Employment laws and Laws on Maternity Leave and Constitutional provisions considered supra]

As indicated in discussing the cross cutting principles of discrimination some principles of family can discriminate against unwed parents and children. According to the law of guardianship the responsibility for children fall exclusively on the unwed adolescent mother, unless there is voluntary support from wider family members, or paternity is proved in court proceedings on family support, or paternity is acknowledged. The law on inheritance discriminates against non-marital children who cannot inherit intestate from their fathers or have limited rights of inheritance. [General Law – Matrimonial Rights and Inheritance Ordinance 1876, Kandyan Marriage and Divorce Act 1952]. The status of the unwed mother emerges from the birth certificate since information on parents, and whether or not they are married has to be indicated in the birth certificate. An unmarried man has no obligation to report the birth of his child, but he can acknowledge paternity when the birth is registered. Where this is not done the unwed mother, who claims child support in legal proceedings is required to prove paternity.

The stigma of illegitimacy therefore remains in the law on guardianship and inheritance, though it has been eliminated through amendments to child support and Citizenship law. [Maintenance Act 1999; Citizenship Act 2003]. The limitations in the law reinforce negative attitudes to unwed mothers who are thus vulnerable to terminate a pregnancy through unsafe and illegal abortion or infanticide after a birth. Both abortion and infanticide are criminal offences under the Penal Code and women are prosecuted for these offences.

The right to privacy is not guaranteed in the Constitution but Art.106 provides for proceedings in camera when children's' concerns surface in family or sexual cases and this includes proceedings where medical evidence is relevant. Other aspects that may have a bearing on national human rights standards are discussed in Part 11. 3.7.

Sri Lanka's education and health policies over the years, rather than human rights considerations had a positive impact on reducing the

incidence of early marriage mortality and morbidity. The current framework of human rights standards provides a supportive context for introducing new policies and interventions to eliminate gaps and ensure the highest standard of RH care for adolescents. Both the health and education sector needs to give priority to this age group especially in creating awareness among adolescents and their families of both the human rights standards and the possibility of making use of services targeted to this group.

3.1.3. State effort on laws, regulations, policies and implementation

3.1.3.1. General Social and Health Policies

Maternity care had been one of the success stories of Sri Lanka relative to other developing countries.

Since the development of the Civil Medical Department in 1857-the Sri Lankan government has assumed responsibility for providing health care to every citizen. The first organized effort of providing maternity care had been made as early as 1879 with the establishment of the De Soyza Lying in Home .Primary Health care was initiated by Governor Sir Gregory in 1872 First village level dispensary started in 1877 **(131)** The parallel development of field care was one of the key factors for the success and the first Health Unit system was established in 1920.

This decentralized Unit resulted in the establishment of smaller institutions and MOH offices spreading to grassroots. There was further decentralization of Health care especially at Primary Health Care (PHC) level from 1987, with the establishment of Provincial Governments.

Following the Declaration of Alma Ata in 1978 Sri Lanka signed the Charter for health development on 1980 for achieving the goal of health for all by the year 2000 adopting the strategy of primary health care including the maternity care.^{131, 114}

In addition, other general social and health welfare programs would have indirectly contributed towards the good perinatal figures of Sri Lanka.

The high literacy rate in Sri Lanka can be related to the policies and investment and implementation of education by government and which

has a direct impact on the health services and thus on maternal and infant care^{132,133}

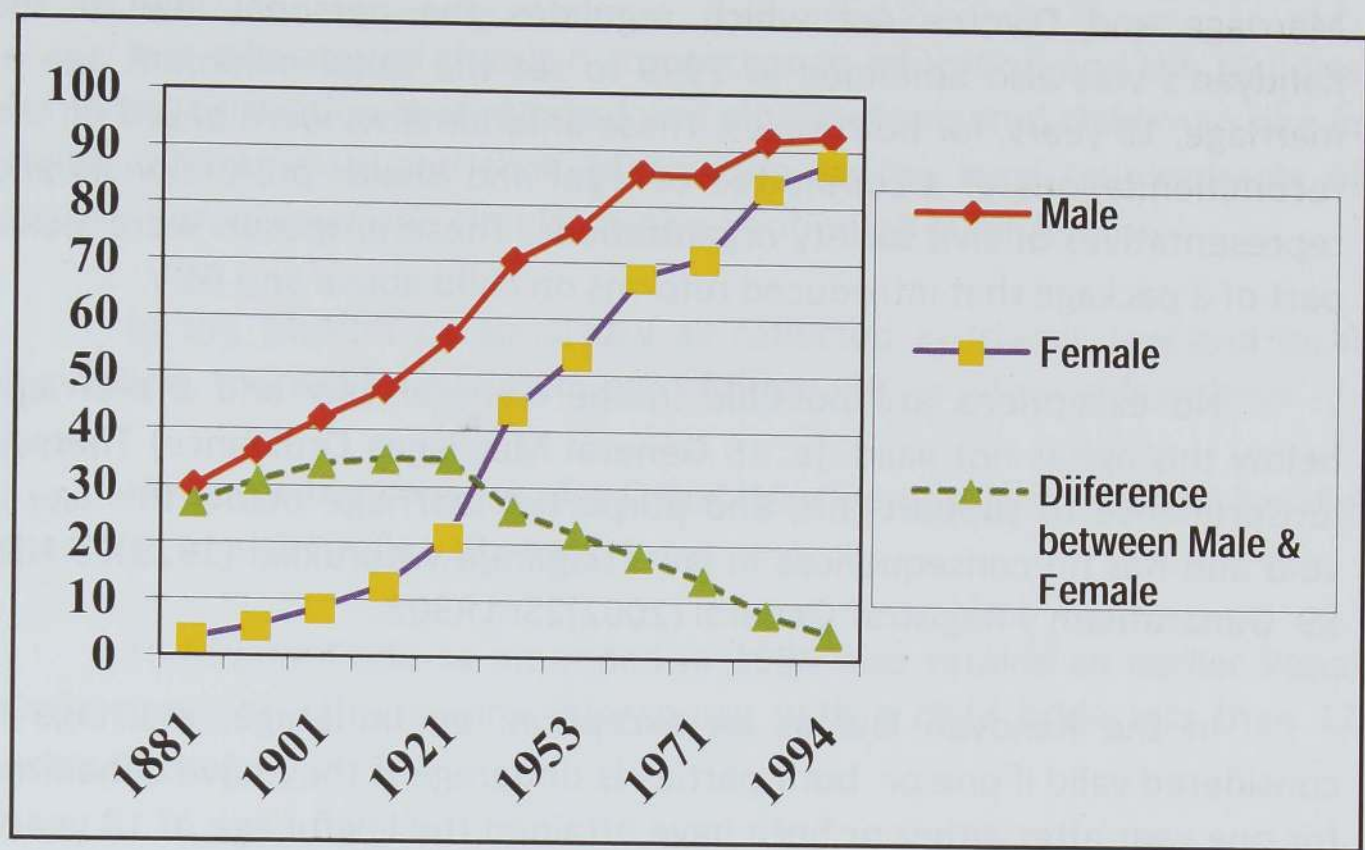


Figure 05: Literacy Rates by Sex 1881-1994

There has been a dramatic improvement in female literacy (Fig 05.) since the introduction of free education in 1948, the trend of which coincides with the improvement in the Maternal, neonatal and infant mortality figures (Fig earlier).

3.1.3.2. Monitoring and accountability

One of the significant reasons for the successful functioning of the care provision is the system of monitoring existing in the form of ‘monthly returns’ on all aspects of primary health care up the hierarchy to the central Family Health Bureau (FHB). This system is enhanced by the presence of medical professionals who would be capable of interpreting the data and make necessary recommendations

[Source:^{108, 120, 134, 135, 136}]

3.1.3.3. Law on Early and Forced Marriage

The General Law on Marriages Registration Ordinance (1907) which originally applied to all persons not subject to two personal laws (Kandyan Law and Muslim Law), indicated different minimum ages of marriage for

girls and boys. In 1995, the same minimum age (18 years) was adopted for both sexes by an amendment to this ordinance of 1907. The Kandyan Marriage and Divorce Act which regulates the personal law of the Kandyan's was also amended in 1995 to set the same minimum age of marriage, 18 years, for both sexes. These amendments were based on the recommendations of a committee of legal and health professionals and representatives of civil society organizations. These proposals were also a part of a package that introduced reforms on child abuse and GBV.

No exceptions are possible in the General Law and a marriage below this age is not valid. (s. 15 General Marriages Ordinance) There is jurisprudence to support this, and purported marriage below this age is void and has no consequences in law (*Tiagaraja v Kurukkal* (1923)25 NLR 89 *Gunaratnam v Registrar General* (2002)2Sr.LR302.

In the Kandyan law as an exception, an underage, marriage is considered valid if one or both parties is underage if they have cohabited for one year after either or both have attained the lawful age of 18 years, or if a child is born to them before reaching the minimum age (s.4(2) 4(3) Kandyan Marriage and Divorce Act) It is not clear how this legal provision is being implemented. Since registration is mandatory, it would appear that the marriage will be registered later once these conditions are satisfied. Marriage in these exceptional circumstances where parties are minors, subject to Kandyan law will raise issues on, whether the adolescent becomes an adult on marriage. This issue has not surfaced in reported cases.

Some groups who work on children's issues are concerned with the incidence of teenage pregnancy among unmarried adolescents in an environment where abortion is a criminal offence. They argue that the age of marriage should be lowered again to 14 years to take account of the reality of teenage pregnancy. There are no published national statistics on the number of teenage pregnancies. However available information shows a relatively high incidence.

In any event the arguments to lower the age of marriage are not accepted by gender advocates and most health professionals who suggest

that the response should focus on increasing community and adolescent awareness of responsible sexual behavior, and access to contraception.

It is also argued that it is the access to education and the facilities for birth registration that reduced and almost eliminated child marriage in these communities, and that information on the legal requirements of registration of marriage should receive continuing publicity

In the Muslim personal law as reflected in Islamic law and local legislation, there is no minimum age of marriage for either girls or boys.

However the consent of a Quazi (Muslim priest) is required for the marriage of a girl under 12 years.

The Penal Code as amended in 1995 also retains an earlier Penal Code provision criminalizing intercourse with a child bride less than 12 years as rape.

This provision applies only to Muslims, since child marriage is only legal after 1995 reforms, in the Muslim community. The provision in the Penal Code has not been enforced in reported cases. Child marriage continues to be registered under the Muslim Marriage Act or solemnized according to custom in the Muslim community, though the average age of marriage even in this community has risen over the years to 17-18 years according to a personal communication from the Muslim Women's Research and Action Forum, though national statistics are not available.

Legal majority is not attained automatically on marriage of Muslim minors, but according to Islamic law on reaching "the age of puberty" in the case of both sexes. (The age can vary for each sex).

There is jurisprudence on this aspect recognizing the concept. On marriage, a Muslim girl who has reached this age is considered to have legal autonomy in respect of property, but as in the case of all married women, subject to the husband's marital power in relation to her personal life, spousal consent to decisions will therefore be required. The husband however obtains full autonomy on marriage only after the age of puberty which is 14 to 15 years, but below the age of majority in Sri Lanka which is

18 years. A girl under the age of puberty will come under the guardianship of her husband if he has attained the relevant age of majority in Islamic law, or the general of majority of 18 years. If both are under age decisions will be made by the guardian of the boy.

In the General Law and Kandyan law, the consent of both the man and woman is required at registration of a marriage, and the bride and groom must declare an oath and sign the marriage register. There is jurisprudence that parental consent cannot validate a marriage below 18 years the minimum age of capacity to marry. (See *Gunaratnam vs Registrar General* (2002) cited earlier. However due to the failure to repeal an earlier statutory provision in the General Law of marriage on parental consent (s.22, General Marriages Ordinance) when the age of marriage was raised to 18 years, parental consent remained as an additional requirement in the case of a young person between 18-21 years. In 1997 a further amendment lowered the age of 21 to 18 causing confusion. This confusion in the law should be clarified by repealing the amendment to s.22 enacted in 1997

There is a procedure for moving court if there is parental objection and also a procedure for the Court overriding parental wishes and giving consent, if parental consent is unreasonably refused.

In the case of Muslims, registration takes place at the 'nikah' ceremony of the marriage contract. The consent of the woman is not required at registration of the marriage. The wali or marriage guardian or the Quazi (where he has dispensed with the wali), expresses consent on her behalf. The bridegroom, the marriage guardian of the girl (wali), and two witnesses must sign the register. However, she can repudiate the marriage on various grounds after reaching the age of puberty, or through the Quazi. Similarly as mentioned earlier, the consent of the Quazi is required for the marriage of a girl under 12 years.

Since a bridegroom must sign the marriage register his consent appears to be required. The consent of his marriage guardian (wali) is an additional requirement under Islamic law on marriage guardianship, but is not reflected in the Sri Lanka legislation. It seems as if the law assumes

that the bridegroom will be above the islamic age of majority (puberty) and will not require a guardian to express consent.

In the General and Kandyan law duress or forced marriage is a ground for having the marriage declared void in Court proceedings. This is based on principles of Roman Dutch Law, and the interpretation of the statute, which requires consent to be recorded. Jurisprudence on Islamic law in other countries (e.g. Pakistan), suggests that forced marriage is not valid in Islamic law, and a woman's consent is required. There is no jurisprudence developed by courts on this aspect in Sri Lanka. However there is jurisprudence recognizing what is described as "the option of puberty" in Islamic law i.e. the right to repudiate the marriage after reaching this age. In Sri Lanka the requirement of the Quazi's consent to the registration of the marriage of a Muslim girl under the age of 12 years may have been introduced as a restraint on early/ forced marriage.

There are no criminal provisions in marriage laws punishing those who force the solemnization of a marriage.

In Non Muslim communities, early marriage is considered a marriage below the minimum age of marriage. An "arranged" marriage on the other hand has social legitimacy as a marriage where parties are introduced to each other by parents and relatives, and consent to get married with the approval and blessings of these adults. Though they have not found their own partners, the legal requirement of expressing individual consent to marry, and the possibility of invalidating the marriage for duress eliminates the perception that an arranged marriage is a forced marriage. It is possible that some arranged marriages are solemnized because of undue pressure from parents and relatives. However the man or woman's refusal or failure to exercise their legal right to individual autonomy and express consent at the time of registration is not addressed by criminalizing the conduct of persons who compel others to marry against their wishes. Acts of intimidation in general are criminalized in the Penal Code, but these provisions have never been used to respond to compulsion used in relation to marriage.

3.1.3.4. Registration of Marriage

There are laws on registration of marriages under the General Law, Kandyan Law and Muslim Law. These laws combine with access to education have contributed to the low incidence of child marriage in Sri Lanka.

The requirement is not mandatory in the case of persons governed by the General Law and Muslim law. These marriages may thus be solemnized according to custom but the others requirements of capacity etc. as set out in legislation and or Islamic law must be satisfied. The exception of non-registration only applies to the form or method of solemnizing the marriage.

However in Kandyan law, failure to register makes the marriage void in law. This requirement was introduced as colonial policy by the British administration, and has not been changed. There is no difference in the law on registration based on sex.

Specially appointed Civil Registrars of Marriages register marriages in the case of persons governed by the General law and Kandyan Law. Only males can be appointed under the Muslim Marriage Act to register marriage in Muslim Law. Registration can be done in the official registration office, or in a private place.

In the case of Christians, the Priest who officiates at the ceremony has been empowered under the marriage legislation to register marriages under the General law.

The Registrar's certificate is considered the marriage license for all purposes and evidence of the marriage. Where there is no registration of a General Law or Muslim marriage, solemnization according to custom or religious rites must be proved in Court proceedings. There is general awareness among the public of the need to register marriages, as facilities for registration of marriage are accessible even in rural areas. Mobile services are also available to cater to the IDP's in the conflict areas.

Sri Lanka's law and policy on early and forced marriage in non Muslim communities the accessible procedures and free education

policies already referred to have contributed to the increased literacy of girls and virtual elimination of early and forced marriage. In recent years there is anecdotal evidence that there is pressure on girls to marry early in conflict areas to avoid conscription by Non State armed groups. The disruption in education also contributes to the pressure on girls to marry young. There is evidence of corruption in the falsification of entries in birth registers and marriage registers for purpose of registering under age marriages. (Daily News 5th September 2006 Report Headlined “fifty registrars suspended over underage marriage registrations”)

3.1.3.5. Registration of Births

Sri Lanka had a long history of providing access to birth registration. However, there is evidence that procedure for birth registration in the plantation sector is complicated and results in delays. This means that a child in these communities may not have a birth certificate though some efforts have been made to eliminate discrimination against marital and non marital children, from 1999 (see earlier reference), the child of an unwed mother is considered an “illegitimate child”. As pointed out earlier in discussing discrimination as a cross-cutting principle such a child has a diminished legal status in some respects. In regard to birth registration there is no obligation of the father to report the birth or acknowledge paternity. This is his choice. If he acknowledges paternity, his name is entered in the birth certificate. The status of the relationship of the parents and whether they are married or not, is also indicated in the birth certificate. Circulars were issued a few years ago enabling an unwed mother to produce an affidavit instead of a birth certificate at the time of school admission. This was a response to anecdotal evidence that unwed mothers and some low income families in the plantation sector did not have birth certificates for their children, prejudicing school admissions. It appears that this practice of accepting affidavit is not followed because of some uncertainty regarding the scope of the circular. Mobile clinics were conducted to facilitate birth registration after the tsunami. These mobile clinics continue to operate today and facilitate birth registration. The ICCPR Act 2007 now recognizes the right of a child to have birth registered, and also provides a remedy in the High Court for infringement of this right.

3.1.3.6. Polyandry and Polygamy

The right of a woman or man to contract a second marriage was considered a HTP (Harmful traditional Practices) and abolished by legislation on marriage enacted in the British colonial period, except for Muslim males whose religion was considered to permit the polygamy. Consequently Non-Muslim polygamous and polyandrous marriages have been illegal for almost 150 years. Bigamy is a criminal offence for non Muslims and is prosecuted. Access to marriage registration and education has contributed to the awareness that polygamous marriage is illegal.

The exception relating to Muslim Marriage has not led to a high incidence of male polygamous marriages. It is very rare even in the Muslim community.

At one time jurisprudence based on a judgment of the Privy Council based in the UK (then the highest Court of Appeal) permitted a convert to Islam to claim the right to contract a legal polygamous marriage, despite having contracted a first marriage under the Non-Muslim monogamous General marriage law (*Attorney General v Reid* (1963 65 NLR 97)). This decision was however considered and overruled in a more recent case by the Supreme Court of Sri Lanka (*Abeyesundere v. Abeyesundere* (1998) 1 Sri LR 185). Consequently a convert to Islam cannot contract a second marriage under Muslim personal law unless he obtains a divorce from his first wife whom he married under the monogamous General Law of marriage.

Since polygamy is part of Islamic personal law and there is a low incidence there have been no sustained advocacy efforts among Muslim women's groups on abolition of polygamy.

3.1.3.7. Dowry

Dowry is defined in Sri Lanka as a gift given on marriage to a daughter.

In Sri Lanka the giving and receiving of dowry is openly acknowledged including in advertisements in the press. Some incidents of dowry connected domestic violence and divorce which are due to tensions over nonpayment of promised dowry have been recorded, but not on the scale in the subcontinent. Consequently there has not been a consistent or

articulate lobby to abolish it. Jurisprudence in Non-Muslim law and Tamil personal law also recognizes dowry as a marriage portion that belongs to the separate property of a married woman.

Muslim women's groups have identified dowry as a social practice that conflicts with Islam, and have lobbied unsuccessfully to have it prohibited as a custom that puts economic pressure on families, rather than as a cause of domestic violence and divorce.

Dowry as a HTP (Harmful Traditional Practices) has been raised in gender studies and is considered discriminatory since it is increasingly given as a marriage gift to the bridegroom. Yet there have been no public awareness campaigns to undermine even this form of the practice or a lobby for legal reform prohibiting gifts of dowry to a woman or a man.

3.1.3.8. Parental Rights and Evolving Capacities

Family law has entrenched a strong concept of parental rights and responsibilities for all communities whether under the General Law or personal laws of communities. However we have seen that jurisprudence on guardianship also recognizes a concept of the child's best interests and an "age of discretion" at which autonomous decision making is legal. It has been noted that since the latter concept is not clearly stated in legislation, the concept of an adolescent's right of informed consent remains a matter of interpretation.

The concept of giving the best interests of the child paramount consideration in the work of legislative bodies, the executive and the Courts, has now been recognized in the statement of child rights in the ICCPR Act S. 5. This provides a rationale for recognition of the right to privacy and confidentiality and informed consent in the area of health in the case of adolescents who have evolving capacity or have reached the age threshold of discretion, modifying the rights of parents and guardians. It has been noted that even before the 2007 legislation, jurisprudence on custody and guardianship had interpreted the concept of best interests to modify parental rights. Consequently specific legislation to clarify a right to privacy and confidentiality and informed consent regarding medical decisions in the case of all persons including adolescents need not be viewed as undermining family law standards on parental rights and

responsibilities. Since Constitutional amendment is difficult these aspects can be dealt with either in health or specific legislation, so that the gap in the law can be addressed.

Consequently the legal position is that an adolescent at the age of discretion has a right to express informed consent. They have a right to be consulted and make independent decisions.

A provision in the Human Tissue Transplant Act 1987 permits parents to donate an organ of a child less than 21 yrs. This is in conflict with the law on age of majority and age of discretion, and should be repealed. (Sources/Additional Information: Goonesekere S. Sri Lanka Law of Parent Child. Note 59, Muslim Personal Law in Sri Lanka: Muslim Research and Action Forum 2000, Beijing Reflections :Center for Women's Research 2000 Chapter1, Facets of Change: Center for Women's Research 1995, Chapter 2, "Early Marriage: A New Challenge" in Partners in Progress: National Committee of Women 2004, Vol 2/No.3 p 59, Gender Equality and Empowerment of Women: ICPD-15 Years On FPA Sri Lanka 2009 and Kalinga de Silva "Marriage Transition and its Impact on Demographic Change ibid p 41)

3.1.3.9. Maternal Mortality and Morbidity among Adolescent girls

Although there is no law on reducing maternal mortality many policies indirectly ensure this objective. As early as 1993 The Woman's Charter¹³⁷, under the Topic: Right to Health Care and Nutrition iterates that the State shall ensure provision of health care to both women and men without discrimination (However no particular mention of adolescents or youth) However Population and Reproductive Health Policy¹³⁸ 1998 under Goal 2 known as "ensure Safe motherhood and Reduce Reproductive Health System related Morbidity and Mortality" there is an attempt to address this issue more specifically.

The proposed Maternal and Child Health Policy 2008 Sri Lanka¹³⁹ identifies "Empowering children and adolescents to make informed choices regarding their sexual and reproductive health issues" as a strategy.

The Action plan on Population and Reproductive Health Policy (138) under Goal 2 addresses the issue of adolescent pregnancies indirectly by trying to improve their “Responsible “behavior by way of education and advocacy. However, in this document it is not considered as a rights issue. The “protectionism” rather than ensuring Rights appears to be the attitude of policy makers throughout the formulating of these policies.

3.1.3.10. Support For Adolescent Parents

Though Children’s Charter Art 16 refers to the State obligation to give access to child care facilities there are no affirmative measures or laws fostering positive and supportive attitudes. Sri Lankan law reflects a policy of discouraging and prohibiting child marriage below 18 years, on the rationale of health grounds and deprivation of childhood

The official communication instrument of the FHB, which is the Annual Report of FHB in 2004-2005¹⁰⁹ states that “The programme managers should conduct special reproductive health education programmes for adolescents in school and out of school on ill effects of teenage pregnancies and the need to postpone pregnancy till the women are matured enough to go through a safe pregnancy and childbirth” However they can access free health services. The Circular No 02/20/2007¹⁴⁰ identifies women less than 15 yrs if living together to be included in the Eligible Couple Register (Health 526) for provision of care by the PHM. In addition any woman of any age, if pregnant is considered as suitable candidate for Maternity care provision. These two statements from the FHB cover the provision of care for pregnant adolescents.

Though there is no law or policy specifically in place to support pregnant adolescent girls and young women they come within the laws regulating maternity benefits for working women in the formal sector .Since the minimum age of employment is 14 years Sri Lanka’s maternity leave and benefits law applies to married and unmarried workers in the formal sector. They are relevant for adolescents since the legal age for employment is fourteen years. Maternity leave laws and policies regulating the private sector however discriminate against the third child, by giving only six weeks of paid leave in their case, and 3 months in the case of the first two pregnancies. [Employment of Women and Children’s Act 1957 (legal age of employment of adolescents); [Shop and Office

Employees Act Maternity Benefits Ordinance as amended 1985] (maternity benefits and leave] This policy has been further changed in 2005 to expand maternity leave in the public sector by an amendment to the Establishment Code regulating the public service. According to the new policy employees have a right to additional half pay leave for six months and no pay leave for one year for the explicitly stated purpose of care of the newborn. The continued difference in policies the public and private sector is an infringement of CEDAW standards as well as the standards of the CRC and ICCPR Art 24 on the rights of the child to health care and development. However the legislation cannot be challenged as a violation of equality since past laws are not subject to judicial review for violation of fundamental rights. [Art 16]. This is an area where the conflicting interests of population and economic policy (incentives for workers to have a two child family), come into conflict with the concept of adult choice in family planning, as well as the development rights of children.

Adoption facilities are available with the consent of the adolescent who wishes to place a child in adoption, through NCPA. NGOs supported by the state probation and child care authorities also provide this facility. NGOs e.g. Sarvodaya provides psycho social support and shelter for teenage mothers.

3.1.3.11. Provision of Crèche Facilities

The National policy on early childhood care and development (ECCD) October¹¹⁸ in section 5.2 under the topic of day care facilities (crèches) discusses the importance of providing day care facilities. "In certain sectors of the society such as estates where most mothers are employed it is mandatory for employers to provide crèche facilities, physical facilities in estate crèches have been upgraded with UNICEF advocacy and assistance and conditions are much better from what they were before. Some crèches attendance have also been trained on ECCD" Certain government and Non government organization with a high concentration of women workers do provide crèche facilities.

Ministry of child development and women's empowerment has developed Guidelines for child development centers including the above mentioned ECCD centers.¹⁴¹

3.1.4. Barriers in Laws, Regulations and Policies

1. There is lack of support for women's groups who have lobbied within Muslim community to change the law of age of marriage consent to marry dowry, polygamy and guardianship responsibilities.
2. Lack of knowledge among adolescents, their parents and health providers on the minimum of age of marriage, age of discretion and privacy during evolving capacity and the age of sexual consent encourages early cohabitation and child bearing among adolescents.
3. Some laws and policies continue to discriminate against non marital children and adolescents who are considered illegitimate children. Registering births in the plantation sector involves delays and complicated procedures resulting in a failure to register. Requiring information on marital status in birth registers can also have a negative impact on an adolescent unwed mother registering the birth of a non marital child. Revised circulars of the Ministry of Education of accepting affidavits in school admission for children without birth certificates lack clarity and are not being followed. There are also discriminatory provisions on the legal rights of non marital children in the area of inheritance and parental rights.

(3a) Registration of marriage procedures are being undermined by corruption in falsification of birth and marriage registers in order to legalize under age marriage particularly in conflict affected areas. This has not been addressed effectively.

4. There are no criminal provisions in marriage laws punishing those who forced and solemnized marriage and the non Muslim marriage legislation does have clear provisions incorporating the jurisprudence that forced marriage and under age marriages are void and illegal and do not have any legal consequences.
5. Parental consent is required for marriages 18-21 years. The Human tissue Transplant Act 1987 also permits a parent to donate an organ of a child less than 21yrs. These provisions conflict with the definition of adulthood as well as concept of evolving capacity and age of discretion.

6. Only males can be Registrars of Marriages under the Muslim Marriage Act.
Polygamy is permitted for Muslim men increasing the risk of under age marriage.
7. There is no legislation prohibiting exploitative practices in giving and receiving dowry by the man. (Addressed in detail in sexual health)
8. Medical personnel are unaware of the concept of best interests of the child, law on evolving capacity and age of discretion of 16 years as there are no guidelines for determining best interests, and the concept of age of discretion is not clearly stated in legislation and not incorporated in medical guidelines.(This point is considered in details in the recommendations on sexual health)
9. Adolescents are not specifically identified in health policies to avoid unwed pregnancies and underage marriages. The negative attitude of some of the health care workers towards pregnant adolescents particularly if they are out of wedlock which results in their making a moral judgment which affects the care provision.

Although Grass Root health care worker is often the first contact point for the adolescent seeking information or services regarding avoiding an unwanted pregnancy or assistance once pregnant they are not trained specifically to support adolescents with sensitivity. The adolescent who may be physically developed enough to conceive, is often not adequately developed to cope with the mental stresses of child bearing. She needs much assistance with psychosocial counseling and support. This is a special need and the state sector does not have adequate personnel capable of offering such assistance.

10. There are inadequate facilities for counseling and shelters. The facilities offered by NGOS have very limited coverage. (Also see sexual health)
11. The health delivery has been the main focus of interest in conflict areas, while specific data on reproductive health in general, including

that of adolescents has been lacking. In conflict areas and IDPs, education is often compromised. This has negative impacts on adolescent sexual behavior and unwanted pregnancies.

Adolescents in the IDP groups are vulnerable to sexual abuse and coerced sex and access to information and services to contraception inclusive of emergency contraception is a barrier

12. Lack of awareness of health and legal professionals of the need of in depth investigations focusing on the possibility of an unwanted pregnancy being the precipitating cause in cases of suicide of an adolescent.
13. There is absence of national data on teenage pregnancies on most aspects including morbidity/specific morbidity, mortality patterns, IDP and other vulnerable groups, disaster situations, Caesarian section rates etc.
14. Maternity leave laws and policies have been developed in an ad hoc manner and have not attempted to balance conflicting pressures of labour standards and economic interests of the private sector. This has resulted in problems of law enforcement and implementation. Adolescent seeking employment in the private sector may have to face a situation where employers are reluctant to employ them and give this leave. The facility of 1 hours leave without loss of benefits after the 5th month of pregnancy and to breastfeed the child up to the age of 5 months, given to state sector employees is not offered to private employees. Some employees especially in the private sector may not calculate the 84 working days leave given to all mothers properly and the mother may not complain to labour authorities for fear of losing employment. The optional 6 months half pay and 1 years no pay leave after delivery is offered only to state employees while the grant of leave may vary in different state sectors.

3.1.5. Recommendations

1. MoH and MoE should engage in a conversation with Muslim women's groups, so as to support their efforts and address the issues they have

raised from a public health and education as a human right perspective. They should be provided with health information that can help to develop public health and human rights messages relevant to early and forced marriage and female circumcision.

Responsible authority: MoH, Ministry of Muslim Affairs, Women's bureau, Ministry of Human Rights, MoE, Ministry of Justice, submit a cabinet paper

2. Sensitization activities need to be implemented to disseminate the knowledge regarding the age of marriage, age of discretion, privacy in evolving capacity, age of consent for sexual consent, Penal Code provisions with respect to statutory rape. The target groups should be **in and out of school** adolescents and youth, parents and teachers.

Responsible authority: Registrar General/ Ministry of Justice ,Grama Sewaka Niladari to make aware Vulnerable groups, Health care providers including PHMs, Trade Unions of relevant public officers and Women's Groups

3. Introduce changes to birth registration laws so as to encourage registration of birth of non marital children of unwed mothers. Eliminate entry required on parent's marriage and information on paternal ancestry. Since the citizenship law amended in 2003 there is no discrimination between marital and non marital children regarding acquiring citizenship through either parent. Review laws on the status of the non marital child and the circulars on school admission with affidavits, where there are no birth certificates. Strengthen birth registration procedures where there is lack of access and awareness including in the plantation sector.

Introduce strict monitoring and disciplinary measures to prevent corruption in falsifying birth and marriage registers. The corporation of professional bodies of registrars should be obtained to develop and monitor codes of practice. Amendments to General Marriage Ordinance which applies to the majority of Sri Lankans to incorporate jurisprudence that an underage and forced marriage is void i.e. has no legal consequences.

Responsible authority: Registrar General, Ministry of Justice and Ministry responsible for legislation on General Law Marriages

4. Specific penalties should be introduced in marriage legislation to punish persons who solemnize early marriage or intimidate and threaten parties prior to registration of marriage so as to prevent them expressing free consent.

Responsible authority: Ministry of Justice, Registrar General

5. Introduce amendments to the General Marriages Ordinance and the Human Tissue Transplant Act in order to harmonies with the Age of Majority Ordinance and the concept of age of discretion and evolving capacity.

Responsible authority: Human Tissue Transplant Act- MoH, Ministry of Justice, Marriage Ordinance, Registrar General

6. Support the appointment of significant number of women registrars of marriage, since they may help to provide greater access of facilities to families.

Responsible authority: MoH and MoE to support women's groups, advocating for changes in regard to polygamy, by providing information on health and education as a human right of all girl children.

7. Legislation to avoid exploitative practices in giving and receiving dowry.

Public awareness raising on the harmful effects of exploitative practices of giving dowry to the man. (See specific recommendation on sexual health)

Responsible authority: Ministry of Social Services, Public Administration

8. Introduce amendments to ICCPR Act with reference to definition of adolescents and the age of discretion. Repeal all legal provisions that conflict with the legal definition and amend policy documents accordingly as suggested in recommendations on sexual health. Introduce guidelines on procedures for obtaining an adolescent's views and for determining the best interest concept in a schedule to the ICCPR Act as in the case of Tsunami Special Provisions Act.

Make medical professionals aware on these legal standards

Responsible authority: MoH, Ministry of Justice

9. Adolescents should be addressed specifically in health policies to prevent births out of wedlock and unwanted pregnancies.

Responsible authority: MoH

10. Provide facilities for counseling and shelters with the corporation of NGOS. (Also see sexual health)

Responsible authority: MoH, Ministry of Child Development and Women's Empowerment (MWE), National Committee on Women (NCW)

11. National data collection institutions need to be strengthened to obtain data from the conflict affected areas with respect to adolescents and analyzed in an action oriented manner

Special attention needs to be given to the provision of contraceptive services inclusive of emergency contraception to the adolescents in conflict and IDP situation in a confidential and sensitive manner

Make necessary arrangements to ensure continuation of education in the conflict and IDP situations. Special emphasis be placed to include the SRH education as given in the curriculum recommended by the MoE in this activity.

Responsible authority: Ministry of Rehabilitation and Reintegration, MoH, MWE

12. Sensitization of the relevant authorities in considering the possibility of unwanted pregnancy as a precipitating factor for suicide or attempted suicide among adolescents. This could be linked with a data collection methodology to identify any trends and plan suitable interventions.

Responsible authority: MoH, Ministry of Social Services, NCPA ,Ministry of Women's Empowerment an Child Development

13. There should be specific emphasis on the routine data collection from the grassroots to the FHB, focusing on adolescents. The present system including data collection forms should be modified to accommodate adolescents. In addition, there should be support for

national surveys on the incidence of early marriage and particularly in areas affected by conflict. Surveys should also be undertaken on teenage pregnancies including the health dimensions as evidence based research to support policy formulation.

14. Review and rationalize laws and regulations on maternity leave. Encourage the private sector to respect the maternity leave and benefits for women and adolescent workers and their children. They should be encouraged to manage the demand for economic efficiency without prejudice to the rights of women adolescent workers and their children. Create awareness among married and unmarried adolescents' workers regarding laws on maternity leave and benefits and their entitlements.

Responsible authority: Ministry of Justice/ Ministry of Labour/ Employers Federation/ Chamber of Commerce/ Trade Unions

3.2. Family planning

3.2.1. Health situation

At present family planning services are available through three main avenues .The first is the state sector field delivery of FP services to the doorstep through the family health officer (Public Health Midwife). The second is through the network of Family Planning Clinics attached to State health institutions spread throughout the country. The third is the private sector care providers and the pharmacies which are progressively providing an increasing share of the service provision.

The National programme delivering contraceptive services is coordinated by the Family Health Bureau of the MoH with the technical guidance provided by the Professional Colleges such as the College of Obstetricians and Gynaecologists and the College of Community Physicians

The State Family Planning Package offers provision of long and medium term contraceptives such as "injectables" and implants as well as the sterilisation services free of charge. A nominal fee amounting to.... for oral contraceptives and 0.045 USD (0.05 Rs) for condoms is levied in the State Sector. The corresponding cost for the same in the private sector is 0.8 USD (90/= Rs) for OCP one month supply and 0.07 USD (8/= Rs) for a condom respectively.

Emergency contraception in the form of 4 tablets of OCP is given in the State sector contraception service package. Emergency contraception is also available at pharmacies island wide at a cost of 0.9 USD (100/= Rs) for a single course of two tablets (Postinor) as an over the counter drug with no age restrictions.

3.2.1.1. Family Planning and Adolescents

The state sector providers are not expected to discriminate between married and unmarried or adolescent and adults in providing contraceptives such as OCP, Condom and “injectables”. However adolescents in the cultural context of conservative attitudes to pre marital sex prevalent in the country may feel embarrassed to walk in to a pharmacy and buy contraceptives over the counter. Condom vending machines are not available at the moment in Sri Lanka. There is anecdotal evidence that initial plans to install condom vending machines were met with protests by conservative elements.

The latest DHS survey 2006-2007 states that of “currently married” women of all ages, 68% is currently using some method of contraception. However, marked variation between districts is seen. The highest “current users of contraception” is seen in Polonnaruwa which is 78% and the lowest in Batticaloa which is 35 %.¹⁴²

According to the DHSS 2006/2007 the current use of contraception among “currently married” aged 15 – 19 is 53.3% for any method and 44.7% for modern methods, and for the ages 20-24 is 57.6 % for any method and 49.7% for modern methods. Relative to other age groups these figures are lower.¹⁴²

Since the minimum age for registration of marriage (after 1995) is 18 years for non Muslim marriages, these figures indicate that some of the “married women” in the age group 15-19 yrs may not in fact, be legally married and are only cohabiting.

There is no stipulated age limit for providing contraceptives, nor is proof of marriage required. Therefore these adolescents can access contraceptives.

The statistics gathered by the FHB too, indicate that women of 15 yrs and above have accessed Family Planning services and there is only a marginal increase in this group over the last 10 years.

Table 05: New acceptor rate per 1000 married women for all modern methods by age group 1994 to 2005

Age group	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
15-19	126.9	142.4	173.4	193.7	196.8	195.4	190.6	191.6	188.0	182.3	172.2	167.8
20-21	138.7	138.9	131.1	161.3	160.7	162.3	163.7	177.3	170.0	171.4	163.4	160.3

Source: (109)

When one considers the information available on different methods used by the “married adolescents” and youth, prevalence of “using any method” has increased from 30.3 in 1993 to 53.3 in 2006.¹⁴²

The marked increase in the use of “injectables” from 5.3% in 1993 to 23.9% in 2006 among the married women aged 15 – 19 was remarkable, compared to the increase in the use of other methods. In this context DHSS 2000 indicates that the knowledge of contraception among “married” 15-19 is very high, reaching 94% for any method (DHSS 2000). The use of traditional methods such as ‘safe period’ and ‘withdrawal’ among adolescents seems to remain unchanged during this period (2006). By contrast a survey specifically on adolescents **(112)** comprising mostly of **unmarried** adolescents found that only 37% adolescents had ever heard of contraceptive methods. The proportion of adolescents who had knowledge on contraception rose with age; 28% of 14-16 y olds and 64% of 17-18 year olds responding positively. A slightly higher proportion of boys than girls had heard of contraceptive methods. Condoms (29%) and pills (24%) were found to be the most commonly known contraceptive methods to adolescents. Emergency contraceptive methods were known to only to 3%of respondents.

These are significant findings when seen in the context of evidence in the same survey that 13.9 % of boys and 2.2% of girls had sex during adolescence (below 18 years) **(112)**¹⁴⁶

In 2006, the literacy rate for Sri Lanka for the age group 15-24 is 95.8%, 94.8% for males, and 96.6% for females (Department of Census and Statistics special Millennium Development Goal www.statistic.gov.lk/mdg). There is a lost opportunity if knowledge on contraception is not imparted to the adolescent population with such a high literacy rate.

Table 06: Method of contraception according to age in 1993 and 2000

Current age	15-19		20-24	
Method	1993	2000	1993	2000
Any method	30.3	52.8	53.6	61.2
Pill	7.1	9.3	12.3	9.2
IUD	3.8	8.1	5.0	5.2
Injectable	5.3	22.4	12.0	26.4
Vaginal methods	0.6	-----	0.0	-----
Norplant	-----	0.0	-----	0.0
Condom	0.8	1.2	2.4	2.5
Female sterilization	0.0	0.0	3.5	0.8
Male sterilization	0.0	0.0	0.5	0.0
Safe period	6.7	6.2	9.3	7.2
Withdrawal	5.4	5.0	7.3	7.9
Prolonged abstinence	0.6	0.6	1.1	1.7
Other	0.0	0.0	0.1	0.0
No of Women	141	161	722	594

Source: (120)

3.2.1.2. Unmet need of FP

Unfortunately there is no information on the unmet need of contraception specifically on adolescents, but the gradual decline of unmet need from 14 % in 1994¹⁴⁷ to 8% among married women of all ages is reflected in the 2000 (DHS 2000) The percentage of women aged 15 – 19 who had the first birth before 18 yrs was only 4.2% which is low possibly because the minimum legal age of marriage is 18 years and it does not necessarily mean that there is no unmet need among adolescents.

3.2.1.3. Consent issues

Since there is no minimum age of marriage in the Muslim personal law, Muslim adolescents may be married under the Muslim Law, as early as twelve years and may even complete their family before 18 yrs.

However current circulars issued by the MoH and practice, discourages sterilization below the age of 26 yrs with a provision given to the Medical Officer to use his discretion and perform a sterilisation provided the couple has a minimum of 3 living children.¹⁴⁸ Under this exceptional situation where sterilization has to be performed spousal consent is required.

Formal spousal consent is not required for contraceptive services other than sterilisation according to circulars or practice, but a joint consultation with the spouse is very much encouraged. The same position has been applied to married adolescents who seek contraception.

3.2.1.4. Parental consent

Contraceptive services are provided to adolescents if requested in the state and private sector. In practice some of the health care workers may be reluctant to provide this service to adolescents.

If a parent accompanies an adolescent for the consultation, in practice parental consent is expected and requested as in other medical procedures irrespective of age of discretion and evolving capacity of the adolescent.

If an adolescent presents by herself and requests contraceptive services, parental consent is not required, but may be insisted on by the care giver.

3.2.1.5. GBV and Emergency Contraception

In the event of sexual violence e.g. rape, emergency contraception is often provided by some judicial medical officers in State hospitals. There is anecdotal evidence that some police stations offer this to victims of sexual violence. Where there is forced sexual intercourse or when the husband/partner prevents use of contraception, the woman is placed at

risk of an unwanted pregnancy. She may also be at risk of further violence if she used contraception.

3.2.2. International and National Human Rights Standards

3.2.2.1. International Human Rights Standards

The issue of number and spacing of children, and access to contraceptives so as to plan a family are regulated by general human rights standards on civil and political and socio-economic rights, and specific standards in CEDAW.

Consequently the ICCPR has standards on freedom of thought and conscience (Art 18) and opinions (Art 19) that prevent State controls which limit access and choice of family planning. These international standards are relevant for unmarried and married adolescents (e.g.No minimum age and children can marry in Muslim Law; the age of marriage in Sri Lanka for non Muslims is 18 years and coincides with the age of majority). Spousal rights and the right to found a family, according to ICCPR refer to persons of “marriageable age”. These standards on spousal rights are therefore only relevant for the Non Muslim youth population above 18 years. It can be argued that, in the Muslim community, spousal rights are relevant only for married Muslim adolescents and not for child marriages.

Art 24 of ICCPR also refers to equal rights and responsibilities in marriage. This indicates that one spouse cannot unilaterally make decisions on family planning, and that each should respect the others wishes, arriving at joint decisions. State regulations in regard to spousal consent to either permanent methods (such as sterilization), or temporary methods of family planning must recognize this human rights standard of equal rights and responsibilities of spouses.

ICESCR Art 10 sets the standard of protection and assistance to the family as the basic unit of society with special protection of mothers during and after child birth, with paid leave for working mothers. A general Article refers to the right of everyone to the highest attainable standard of health, (Art 12). These rights reinforce the adolescent’s right to health and development, and women’s rights protected by CRC and CEDAW They can be interpreted as covering the area of access to family

planning information, and services and the allocation of adequate resources for such services.

CAT sets standards on protection from torture and inhuman degrading treatment which are relevant to the State's responsibility not to introduce measures such as forced sterilization.

CERD standards on the right to access public health without discrimination (Art 5 (c) (iv)) and education and training. (Art 5 (e) (v)) reinforce the human rights standards on access to safe family planning services and information, to be able to make informed decisions and express consent. Both ICERD and ICESCR rights suggest that adequate resources must be provided to develop educational and public health programmes relevant to family planning.

CEDAW has specific standards which are relevant in this area. Art 10 (h) gives women equal rights to access family health care information, including information and advice on family planning. Art 4 (2) refers to protection of maternity and Art 5 (b) to protection of maternity as a "social function." Art 11 refers to the right of employment conducive to the protection of reproduction, maternity leave with pay, and supportive services including child care to combine family obligations with work responsibilities. Art 12, the general article on equal access to health care refers specifically to family planning services and free services where necessary during the post-natal period, which can include family planning. Art 14 (b) refers to the right of rural women to access information counselling and services on family planning as an aspect of the right to health care.

CRC has specific articles on the Best Interests of the Child (Art 3). Non-Discrimination (Art 2) respect for the evolving capacity of children to make their own decisions, within the concept of parental and guardianship rights (Art 12 – 14 and 18) and allocation of maximum available resources for child rights implementation (Art 4). All the provisions are relevant to State obligations to offer family planning services and respect the right of choice and provide family planning information to adolescents. The age threshold for these services will however depend on the national law with

regard to majority, evolving capacity, and the diminishing scope of parental and guardianship rights.

Art 24 (b) (d) and (f) of CRC relate to the right of children including adolescents to necessary health care. These provisions too can be interpreted as covering the area of providing access to family planning services for adolescents in the interests of their sexual and general health. Art 24 (d) and (f) refer specifically to pre and post natal health of mothers and family planning education and services for parents – reinforcing CEDAW standards on equal rights of men and women, but also setting a norm on adolescent mothers and parents.

The general article of CRC on the right to education and information from a wide and diverse source for the elimination of ignorance, (Art 28) and the right to resources, for such programmes (Art 28 and 4), also set a standard in regard to adolescents access to information on family planning. These provisions have been reinforced by Art 17 of CRC which deals with use of mass media to provide information to promote the health and development rights of children. This now covers the whole area of Information Technology.

The right to privacy is covered by international standards in ICCPR. (Art 17). It is not specifically referred to in CEDAW. CRC by contrast specifically refers to the child's right to protection of privacy (Art 16). CEDAW and CRC both emphasise the concept of joint and shared parental responsibility. (CEDAW Art 16 (d) Art 5 (b); CRC Art 5, 18) CEDAW Art 16 (e) also gives both parents "the same right to decide freely and responsibility on the number and spacing of their children and to have access to the information education and measures to enable them to exercise these rights." It would therefore seem that in relation to spouses the right to privacy is qualified by the concept of joint spousal decision making. Similarly the right of the child to privacy in relation to accessing family planning services and information may be limited by the CRC concept of guardianship rights in relation to children below the age considered relevant to recognize the evolving capacity of an adolescent to make independent decisions.

General Recommendations and Comments of the treaty bodies (Expert Committees) have sometimes interpreted these treaty standards and also expanded their meaning. They have not resolved the contradiction in these treaty standards referred to above. The CEDAW Committee's General Recommendation No.21 considers forced sterilization an infringement of the Convention, and emphasizes the importance of voluntary regulation of fertility and access to information and services on family planning. CEDAW's General Recommendation No 24 interprets Art 12 on health as covering health status and family planning information and services for both women and girls, on the basis that Article 12 refers to women's health throughout their life cycle. This GR emphasizes the need to maintain confidentiality and does not address the conflicting concept of joint spousal and parental rights. CEDAW's General Recommendation 19 on Violence against Women clarifies that failure to provide Reproductive Health services leading to illegal and unsafe termination of pregnancy can amount to VAW. Coercion regarding use of contraception can also be considered VAW and within the definition.

CRC Committee's General Comment No 4 of 2003 on Adolescent Health deals with providing access to adequate information and RH services and family planning, irrespective of parental consent. It refers to the need for adolescents to express informed consent, their right to privacy, and confidential advice.

Both these General Recommendations and Comments thus emphasise the individual right of privacy and confidentiality, irrespective of guardianship and spousal rights which have also been recognized in the text of these Conventions. In the case of CRC the conflict may be resolved by interpreting the right of privacy within the concept of an adolescent's right to independent decision making once the age threshold for evolving capacity has been reached. However in the case of married youth there is still an unresolved tension between these individual rights and the standard of joint and shared responsibility for decision making in regard to children, emphasized in both the text of CRC and CEDAW, and CEDAW General Recommendation 21 (1994) on Equality in Marriage and Family Relations.

ICESCR Committee's General Comment No 14 on the Right to the Highest Attainable Standard of health, interprets Art 12 (2) (a) as including the right to reproductive health, including access to family planning, information and resources.

The ICCPR Human Rights Committee (HRC) General Comment No 28 on Equality of Rights between Men and Women (2000) refers to women's right to equality in exercising their right to privacy in relation to RH. This refers specifically to limitations on the number of children, or in regard to sterilization such as obtaining spousal consent, as an interference with human rights of women. However the Committee has not addressed the issue of joint responsibility with regard to contraception.

The CRC Committee in its Concluding Comments on Sri Lanka's 2nd Periodic Report 2003 has referred to the need to implement Art 4 and make budgetary provisions for adolescent health care and eliminate discrimination against vulnerable groups of children, specifically identifying children with disabilities, IDP's, children affected by HIV/AIDS, and children of ethnic and religious groups. The nature of the discrimination against ethnic and religious groups is not clear, but may be a comment on disruption of services for children of the Tamil and Muslim community in conflict areas. The CRC Committee has also commented on the lack of an organized system of RH care services for adolescents, highlighting an important gap. They refer to the need to develop a comprehensive policy on adolescent health and implement the recommendations of the Presidential Task Force on Adolescent Health, including education and access to RH services and counselling.

The CEDAW Committee in its Concluding Observations on the Sri Lanka Report (2002) has commended the State for providing women and men with easy access to family planning (Para 271).

3.2.2.2. National Human Rights Standard

Sri Lankan national laws do not refer to the aspect of rights relating to family planning specifically, though health policies referred to in the situation analysis address the issue. The Domestic Violence Act 2005 now provides a procedure for responding to coercion in regard to contraception that may take place within the family. A cohabiting partner

or family member who interferes with individual choice of an adolescent above the age of sexual consent/ age of discretion/ evolving capacity violates the definition of domestic violence in the Act.

The general principles explained in part I and Part II on the concept of best interest, the right to information, privacy, age of discretion and evolving capacity apply in this area too. Adolescent's rights are recognized depending on evolving capacity. The expanding scope of public interest litigation may also mean that some issues such as limitations on family planning and reproductive health rights can be challenged as an infringement of the right to equality and non-arbitrary treatment (Art 12), or the right to freedom from torture and inhuman or degrading treatment.

3.2.3. State effort on laws, regulations, policies and implementation

3.2.3.1. Evolution of the policy on Family planning

Sri Lanka's policies on family planning generally harmonize with human rights standards. A very successful Family Planning Programme has been implemented since 1953. Initially it was started as a programme conducted by an NGO, by the name of Family Planning Association of Sri Lanka, but the programme was soon incorporated into the National Health Service and up to date continues to provide free contraceptive services to all inclusive of adolescents. The policy was initially based on the right of individual choice in family planning and family well being. In the early 70's there was a state initiative to implement contraceptive programmes as an essential aid to population control. There was a public awareness campaign to give the message that "a small family is gold". With the success of the campaign the policies changed back to recognizing individual's right of choice in planning the family. There was also recognition of the importance of planning the family in RH, children's health and family wellbeing.

3.2.3.2. Challenges to policy implementation

Recently some religious groups have challenged the State's family planning policies and provision of services. They mistakenly perceive these policies and services as an effort to undermine current ethnic ratios which give the Sinhalese community the status of a majority in the country. It must be pointed out that the state has a right under the Constitution to restrict manifestation of religion and culture, in the public interest.

3.2.3.3. Provision of Contraceptive Services

Provision of Family planning services and information as a right of men and women without mention of age is stated in the **National Health Policy 1996**¹⁴⁹

The policy identifies the issue broadly, as “The Government will ensure the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice”.

Although adolescents are not specifically mentioned it could be construed to include adolescents.

The Population and reproductive health policy of 1998(138) attempts to address the unwanted pregnancies in adolescence indirectly by a promoting responsible attitude towards each other and promoting responsible sexual behaviour.

However the policy does not specifically identify adolescents or youth for provision of family planning services.

The same Policy with the objective of ensuring safe motherhood and reducing RH morbidity and mortality addresses the issue of unwanted pregnancy in general terms and again does not specifically mention adolescents.

However in 2002 the government of **Sri Lanka in a country report presented by population division of MOH Nutrition and Welfare 2002**¹⁵⁰ recognized the risk of unwanted pregnancy as an emerging issue confronting adolescents. The report states that the national RH programme should give very high priority to the provision of both education and RH services to adolescents.

This is the first instance where contraceptive services are recognized as a need of the adolescents. However RH is not documented in the report as a right of the adolescents

Draft National Policy on Health of Young Persons being developed by the Ministry of Healthcare and Nutrition¹⁵¹ addresses the issue of preventing early and unwanted pregnancies of adolescents by two strategies. Strategy 3.4 identifies provision of targeted information and counselling specifically on provision of contraceptives. The strategy 3.5 identifies provision of targeted services and commodities. It specifically mentions providing condoms and contraceptives to sexually active young people. There is no clarification as to whether the phrase includes adolescents.

The Draft Maternal and Child Health Policy¹³⁹ which is being prepared by MoH seeks “to empower children and adolescents to make informed choices regarding their sexual and reproductive health issues”.

3.2.3.4. Family planning information and counselling

The earlier discussion on national human rights standards indicated a legal environment supportive of recognizing an adolescent’s right to privacy, family planning information and services depending on evolving capacity and the age of discretion. The most recent health policy referred to above conforms in general with the law.

The Health Master Plan 2007-2016¹⁵² while dealing with programmes for organizational Development addresses the aspect of information and counselling for adolescents, youth and their parents. The objective of this strategy is to increase awareness of sexual and reproductive issues, including the importance of responsible and gender sensitive behaviour among adolescents and youth.

The Health Master Plan of 2007-2016¹⁵² states that “Providing family planning counselling to the women in reproductive age at their homes by PHMs...and providing continuous supplies of contraceptive commodities free of charge to the fertile couples has been the main pillars of success of the Sri Lankan programme” The wording is left ambiguous and may be interpreted either to include or exclude adolescents.

Ministry of Health Circular 02-20/2007¹⁴⁰ giving instruction to the PHM on maintaining an Eligibility Register for RH services (Health No 526) identifies women who are eligible for services. Women of any age if

pregnant and any women of 15-19 if married or living together are entitled for these services. At the same time the document excludes the unmarried adolescents who may not fall in to the above category but need contraceptive counselling or services. In practice however the care providers usually do not ask for the marital status when dispensing **condoms or OCP**. They may request information on marital status for other services.

On the other hand **The Family Health Bureau** the state Focal point for contraceptive services accepts **WHO medical eligibility criteria (153)** that allows women less than 18 yrs to access OCP, DMPA, implant, IUCD

3.2.3.5. Parental Rights and Adolescent's Rights in Family Planning

It has been noted in Part I and Part II and in the section on national human rights standards that Sri Lanka has put in place Constitutional provisions which are relevant to the adolescents right to information, equality and non discrimination. A clear right of privacy is not recognized, but there are some policy and legal provisions that support it. These are reinforced by recognition of the concept of best interests of the child and age of discretion, at which there is right to independent decision making. These concepts qualify parental rights to decision making on health and can also be applied to ensure that an adolescent's views are respected, when he/ she is below 16 yrs, but mature enough to take decisions. The subject of informed consent of children and young people and the factors that should be taken into account when assessing competency to consent are covered in general terms in the Guidelines on Ethical Conduct issued by the Sri Lanka Medical Council.

3.2.3.6. Domestic Violence and Family Planning

The Domestic Violence Act 2005 now addresses through a broad definition of DV, coercion in regard to using family planning methods.

3.2.3.7. Vulnerable Groups

Adolescents among street children, IDP's and in the plantation sector come within the general policies on access to family planning services but the delivery of services is hindered by lack of adequate human and other resources to target them specifically. In these situations the emphasis is usually on other priority issues such as infectious diseases,

nutrition and provision of food etc and the importance of contraception may not be given priority.

There is also a legal environment supportive of providing FP services and information to adolescents above the age of discretion, which is 16 years. This age is also the age of sexual consent for adolescents. However, though the State has recognised the need for contraceptive services for adolescents in some policy documents, it appears to be reluctant to directly address it as a need, of these groups. The access to contraceptive services may not be clearly comprehended as a right of the adolescent who is sexually active and above the age of 16 years.

The state effort is mainly directed at behavioural change towards prevention of unwanted pregnancies among adolescents, leaving space for the care providers to allow access to adolescents to contraceptive services at their discretion. The outcome of many strategies including state effort is seen in the gradual increase of the use of contraceptives by adolescents and the increase in new acceptors of the age group 15-19, from 1994-2005 the number of new acceptors of the age group 15-19 has increased by 41 per 1000 married women (32%)¹⁰⁹

3.2.4. Barriers in laws, regulations and policies

1. Government sensitivities to religious and political lobbies and interest groups has prevented successful advocacy in some areas such as sex education in schools. It has also been difficult to develop and deliver family planning programmes for adolescents in other environments. The total fertility rate which had followed a downward trend, increased to 2.4 according to DHSS survey. This indicates a danger that these pressures may lead to backtracking on successful contraceptive programmes.
2. The legal principles governing “age of discretion”, “evolving capacity” and the right to information of adolescents, all of which are relevant to the right to FP, have not been incorporated into policy documents. Policy documents in general do not therefore harmonize with the international human rights standards accepted by Sri Lanka and national human rights standards. The lack of harmonization of these standards in policy documents has prevented the government directly addressing contraceptive issues of adolescents.

One important document that specifically refers to the need for contraception is the national policy on health of young person's which is still in draft stage.

3. The incidence of premarital sexual activity of adolescents is not taken into account in most policy documents that deal with access to FP services. Consequently there is a failure to address this reality in policy documents on FP. This is impacting negatively, particularly on developing effective programmes for preventing adolescent pregnancies.
4. The position of a couple married under the Muslim law under the age of 15 yrs is not covered in the MoH circulars, which refers to age group 15-18 with regard to family planning services.
5. **The Draft Maternal and Child Policy**¹³⁹ mentions that the state undertakes to ensure children (5 to 9 years) and adolescents (10-19 years) realize their full potential in growth and development in a conducive and resourceful physical and psychosocial environment. The strategy developed to achieve this is "Empower adolescents to make informed choices regarding their sexual and reproductive health issues". This has not been implemented at the operational level or the age modified to 18 years in harmony with the law on age of majority and upper age of adolescence.
6. The concept of age of discretion and informed consent in providing FP services is not clearly addressed in MoH circulars. This subject of informed consent of children and young people and the factors that should be taken into account when assessing competency to consent is only covered even in general terms only in the Guidelines on Ethical Conduct issued by the Sri Lanka Medical Council.
7. Inadequacy of resources to address reproductive rights including family planning requirements for vulnerable adolescents such as estate population and IDP's, because other medical issues may override these needs as a priority.

8. Statistical information classifies service receivers as married, without reference to the legal age of marriage which is 18 yrs from 1995 for non Muslims. Adolescents may be identified as married when they are only cohabiting. The statistical information gathered does not harmonize with legal position. but is often used as the basis for Policy documents
9. Lack of awareness of emergency contraception available in the state service package
10. Lack of sensitivity amongst some care providers on the contraceptive needs of adolescents and their rights to these services when they arrive at the “age of discretion”.

3.2.5. Recommendations

1. There should be advocacy programmes to sensitize, religious and political groups, authorities in the education sector, including teachers on the need of awareness programmes on contraception to be included in the reproductive health module in the school curriculum.
Responsible authority: Line Ministry, MoH, MoE, CD & WE, Women’s groups
2. (a) Define **the term** adolescents clearly in policy documents, in harmony with current laws and incorporate the concept of child’s evolving capacity and age of discretion by amendment to ICCPR Act 2007. (see recommendation no.8 of 4.1 on early child bearing)(b) Identify Adolescents clearly and specifically as a target group needing and having a right to contraceptive services on the policy documents including MoH Circulars and health manuals. Facilitate user friendly access to contraceptive information’s and services. This is important because although some adolescents may attempt to access FP services, they may not, all receive adequate services.
(c) Review health policy documents and circulars in the light of international and national standards incorporating them to achieve consistency in integrating rights based approach instead of focusing exclusively on service provision. The MoH should be guided by resources from the NCPA and the Ministry of Education in formulating the policy documents and integrating the rights approach.

Responsible authority: MoH/ NCPA/ MoE /NCW/Ministry of Justice/ Ministry of Human Rights

3. Information and data on sexual activity of adolescents should be taken in to account when developing policy documents. National research on teenage pregnancies should be prioritized to provide an evidence base for policy and law reform.

Responsible authority: MoH/ University Research Centres on Women's Studies

4. The MoH circulars should recognize the provision of family planning services to Muslims legally married according to Muslim law below the age of 15 years.

Responsible authority: MoH

5. Implementation of the Draft Maternal and Child policy to empower adolescents to exercise their rights to make informed choices regarding contraception.

Responsible authority: MoH

6. Clarify the situation and develop guide lines and logistical methodology for implementation of parental and spousal consent to FP services including sterilization ,following human rights standards of gender equality especially CEDAW and CRC.and standards on evolving capacity on CRC to ensure delivery of contraceptive services to adolescents

Responsible authority: MoH/FHB

7. Identify the FP needs and provide resources to vulnerable groups in estate sector and for IDP's, and provide resource to address these needs.

Responsible authority: Ministry of Plantations/ Rehabilitation/ Human rights Ministry/ MoH

8. The MoH information data collection system should recognize and clarify legally married and cohabiting couples in harmony with the laws on marriage as cohabitation and marriage are different according to the law.

Responsible authority: MoH

9. Advocate for policy changes to improve access to emergency contraceptives in the State FP services. Ensure access to emergency contraceptives at the first presentation point for victims of violence.

Responsible authority: MoH/ JMO's/ Police Women's Children's desk/ women's groups working on VAW

10. Train and sensitize health care providers on human rights standards and to respond to needs of adolescents and youth.

Responsible authority: MoH/ Universities/ Child Rights NGO's

3.3. Eliminating unsafe abortion

3.3.1. Health situation

3.3.1.1. Introduction

The Sri Lankan law on abortion is based on the archaic provision in Penal Code of 1883, section 303 which states that performing or procuring an abortion is a criminal offence, but recognizes only the danger to mother's life as a justifiable exception for termination of pregnancy.

However, traditional abortifacients have been used in rural areas perhaps for centuries¹⁵⁴ and illegal abortions are the expected response to unwanted pregnancies.

3.3.1.2. Prevalence

The prevalence of unsafe abortion is difficult to estimate in a country where the law criminalizes abortion. Rates quoted in different studies are 10.9 per 1000 married women of reproductive age in a study using Randomized Response Technique,¹⁵⁵ 42.3 abortions per 100 pregnancies in a study conducted among abortion seekers.¹⁵⁶

A leading researcher on Abortion concluded that there is evidence to suggest that about 125,000 to 175,000 induced abortions are performed annually in Sri Lanka.¹⁵⁷

Even higher estimates have been quoted in the media and when compared with the number of births taking place in the country, it amounts to nearly 2 abortions for every 3 live births. These statistics have attracted public attention, and been discussed at national and

international level, and some proposals for law reforms to respond to the situation were discussed in 1995.

Despite the high incidence of abortion in the country the incidence of abortion among 15-19 age groups is very low according to the available data, relative to other age groups.¹⁵⁶

Table 07: incidence of abortion among age groups

Variable	Study1(13) (n=786) Percentage	Study2(27) (n=306) Percentage	Study3(3) (n=356) Percentage	Study4(28) (n=322) Percentage	Study5(41) (n=75) Percentage	Study6(40) (n=210) Percentage
Age Group						
15-19	3	2.9	3	4.0	5.3	8.6
20-24	15.6	11.4	16	16.5	32	40
25-29	26.6	25.5	25	28.6	22.6	40
30-34	26.1	22.5	27	22.7	30.6	41.9
35-39	20.1	26.8	21	19.9	9.5	41.9
40+	8.5	10.9	9	8.4	9.5	9.5

Source: (156)

The estimated rate of admission to hospitals for unsafe abortion for adolescents and youth is 24 per 1000 women in the reproductive age group. This is a lower rate compared to 66 per 1000 for 35-39 which is much higher¹⁵⁶

Table 08: Estimated Abortion Rates for Women in Reproductive Age Groups, 2000

Age Group	Estimated Rate per 1000 Women
15-24	24
25-29	43
30-34	57
35-39	66
40-49	54
Total	45

Source: (158)

3.3.1.3. Sexual Activity among adolescents

A study done among 446 Advanced level students in Southern Sri Lanka found that nearly half of male students and one third of female

students were sexually active before completion of Grade 12. There were 18.1% of male students and 6.3% of female students who have had a vaginal sexual experience. The authors go on to state that “Traditional value systems have been changed and there are more opportunities for young people to indulge in early sexual activities”¹⁵⁹

The use of contraception among the adolescents is relatively low, considering the findings of a national survey¹¹² which showed that the percentage of adolescents using condoms at the last sexual encounter was 18%. Another worrying finding was that only 2.8% of out of school adolescents stated that condoms were used by them¹¹²

3.3.1.4. Knowledge and Use of Contraception among adolescents

In the study among the advanced level students mentioned earlier only 71% of the male students and 13.7% of female students had seen a condom at the time of the survey.¹⁵⁹

National Survey on Emerging Issues among adolescents in Sri Lanka (112) has information on the proportion that used condoms during their most recent sexual activity, which was only 17%. In addition it was found that more boys than girls reported using condoms at that encounter.

In a study among teenage pregnancies it was found that 61.9% of the pregnancies were unplanned in contrast to 18% pregnancies among the controls who were 19 to 28 years old. The reason for not using contraceptives at the time of conception was given as “ignorance” by 62.7% fear by 3.8% and as their choice by 19.5%. Surprisingly none of them gave unavailability of contraceptives as a cause.¹⁶⁰

3.3.1.5. Reasons for seeking abortions

Age of consent for sexual intercourse is 16 years for both boys and girls, and a pregnancy of a girl below that age is considered as a result of rape, described in law as “statutory” rape of a minor girl, below the age of sexual consent.

The police will therefore prosecute any boy or adult who has sex with an under-aged girl for statutory rape. Since 1995, incest is also a

criminal offence. Consequently there is likely to be pressure to terminate such pregnancies by resorting to an illegal abortion.

A study found that 75.1 percent of the abortion seekers were married women.¹⁶¹ However some of the married women could be under aged adolescents who are cohabiting or girls who have casual relationships and claim to be married to overcome the stigma attached to a pregnancy in an unmarried woman.

Although none of the studies have brought out incest as a cause for seeking abortion, incidence of incest has been quoted as high as 10,000 per year although only 512 cases have been reported for the last five years.¹⁶²

It is possible that pregnancies resulting in an incestual relationship are terminated though not divulged due its sensitive nature.

The legal position as at present is that aborting pregnancies resulting from child abuse/incest/rape would become illegal.

3.3.1.6. Vulnerable groups

Subpopulations such as free trade zone workers, commercial sex workers and internally displaced women have been identified as important vulnerable groups in many studies requiring primary prevention modalities directed towards preventing unsafe abortion.¹⁵⁶ Although these are not studies targeting adolescents. They also could be in these groups.

Sometimes adolescent pregnancies are divulged only in the latter part of pregnancy. Therefore these pregnancies will end in delivery. There may be instances where some obstetricians may be inclined to make a diagnosis of mental depression in the mother with suicidal thoughts / tendencies and perform abortions.

3.3.1.7. Maternal Deaths due to abortions

Sri Lanka has a relatively low maternal mortality of 42 per 100,000 live births amounting to only around 150 deaths for a year of which 10-12 % is contributed by abortion.^{109, 126}

Exact number of maternal deaths among adolescents is not known but according to the information gathered at the maternal mortality reviews the proportion of deaths due to abortions among women of all ages is 10%, which in actual numbers amounts only to 17 deaths in year 2004.¹⁰⁹

The available information, that is, the percentage of deaths of women less than 19 years among all maternal deaths show that it is relatively small and ranges from 4 - 6 % (overview of maternal mortality in Sri Lanka 2001 – 2005 Family Health Bureau Ministry of Health 2009 to be published)¹⁶³

Table 09: Maternal Deaths due to abortions

Cause of death	2001		2002		2003		2004	
	NO	%	NO	%	NO	%	NO	%
Septic abortion	14	8.5	15	7.3	19	12.10	17	11.72

Source: (109,126)

Table 10: Maternal Deaths due to abortions

Year	1975	1980	1985	1990	1995	1996
% of deaths due to abortion	6.2	10.74	11.1	11.3	11.3	8.0

Source: (164)

The maternal mortality Reviews conducted by the Family Health Bureau over the years (Table) have revealed that though the deaths due to septic abortion in terms of numbers have come down gradually over the years, the significance of unsafe abortion as a cause of maternal death is becoming more and more important in that, in 2006 it has become the second common cause of direct maternal deaths¹⁶⁵

On the other hand the total number of abortions taking place is very large and It is quite surprising to see only few deaths due to unsafe abortion occurring in this country with a very restrictive law This paradox not seen in other countries and was called by one of the researchers as “Safe abortion in an illegal context”¹¹²

The reasons for this inconsistency are multiple and include high literacy, easy access to post abortion care, and near 100% coverage of tetanus immunization .

3.3.1.8. Provision of legal abortion services

Safe abortion for those with a medical indication, to save the life of the mother is available to all women including adolescents at state sector health sector specialist units managed by consultant Obstetricians and Gynecologists, free of charge.

Suction termination facilities or medical termination with drugs such as Misoprostol or Mefristone is not available in the State sector. Dilatation and Curettage is used with the use of other oxytocics. The consultants who usually do terminations for medical indications are trained during their postgraduate training on performing safe abortion but the non specialized doctor is not trained specifically to provide a safe abortion service.

The Penal Code contains no procedural requirements or criteria for the termination of pregnancy legally to save the life of the mother, except emphasizing that the pregnant woman’s consent is necessary. There is no mention of the qualifications of those who are authorized to perform abortions or the type of facilities in which the procedures could be performed. The current practice in State hospitals, when the medical condition warrants a termination, is that the decision is taken by two medical practitioners preferably consultants, documented and then the choice of termination is offered to the patient.

The **Guidelines on Ethical Conduct for Medical & Dental Practitioners**¹¹⁷ mentions that, where the law allows therapeutic abortion to save the life of the mother, if there is any religious or moral objections to abortion on the part of the doctor, he cannot be forced to perform or assist in the abortion.

The need of identifying an alternative source of service is not made obligatory or mentioned

3.3.1.9. Knowledge of the law on abortion

The fact that the law is so restrictive is known to most of the public. In a large study on 786 abortion seekers of all ages, 89.4% knew that abortion “on demand” was illegal.¹⁶⁶

However in the experience of one of the researchers; there is a public perception that abortion can be performed to remove abnormal fetuses. This is totally illegal under the present law.

The situation is further **complicated** by the easy availability of ultrasound imaging facility in both state and private sector. Although an abnormality not compatible with life (or with potential severe disability) is identified, the mother is obliged to carry the pregnancy to term according to the existing law. There is no provision at the moment to terminate a pregnancy in a mother who has had rubella or even when a major anomaly of the fetus is identified.

Even the development of the science of antenatal diagnosis by amniocentesis or chorionic villous biopsy is hindered because in the event of identifying an inherited disorder there is no provision to terminate the pregnancy.

Abortion cannot be legally performed in respect of a pregnancy which follows an act of sexual violence such as rape or incest.

Criminalization therefore indirectly encourages women to seek illegal abortion placing women’s health and life at risk and infringing their reproductive rights.

3.3.2. International and National Human Rights Standards

3.3.2.1. International Human Rights Standards

ICCPR (Art 6) and CRC (Art 6) recognize the right to life of “a human being” or a child. Consequently the “pro life / pro choice” debate is avoided in the statement of this standard.

CEDAW has several provisions which protect maternity, perceiving it as a social function [CEDAW Art 5 (b) and 4 (2), Art 12, Art 11] This only focuses on the rights of a woman to maximum health care during pregnancy, and does not conflict with the other human rights standards. Abortion is thus addressed indirectly from the perspective of risk to the woman's right to life and reproductive health, through unsafe termination of a pregnancy.

General Recommendations and Comments of treaty bodies interpreting these standards also do not specifically take a position on the "pro/life or pro-choice" debate. They deal with the aspect of access to family planning and the exercise of choice in this regard, and access to reproductive health services as a dimension of human rights.

However General Recommendations (GR) 19 and 24 of CEDAW do not approve of punitive provisions on abortion in criminal law which encourage women to seek unsafe medical procedures like illegal abortion, considering this a form of violence with risks to health and life. These GRs encourage States to repeal criminal provisions on abortion and eliminate them from the legal system.

Concluding Observations of the CEDAW Committee on country reports also emphasize that restrictive abortion laws and criminal provisions create risks of unsafe abortion that impact on the woman's right to life and health.

They emphasize the need to give access to family planning to reduce unsafe abortion. CRC and HRC and ICESCR Observations also reflect the same approach.¹⁶⁷

The CEDAW Committee in its Concluding Observations on the Sri Lanka report 2002 referred to the need for legislation to permit termination of pregnancy in cases of rape, incest, and congenital abnormalities. (para 282, para 283).

General Comment No 28 of the Human Rights Committee (2000) interprets the right to equality in Art 2 & 3 of ICCPR, and specifically refers

to the issue of reporting cases of abortion as an invasion of the woman's right to privacy.

3.3.2.2. National Human Rights Standards

National Constitutional provisions in Sri Lanka do not address the issue of abortion. The right to life has been recognized indirectly as a dimension of the right to freedom from torture in Art 11, but the aspect of health is not covered in the Chapter on fundamental rights or Directive Principles of State Policy.

The Penal Code criminalizes abortion and imposes penalties on either the woman who permits abortion and the doctor or the person who performs the abortion. They are not culpable if the termination of the pregnancy is to "save the life of the mother." [Penal Code S 303.] This exception has not been interpreted in local jurisprudence, and there have been successful prosecutions of persons including doctors who have terminated pregnancies on the basis that causing the abortion has been proved to be illegal. Abortion is illegal even when the pregnancy is a result of criminal acts of violence such as rape or incest or when severe fetal abnormalities are identified. As referred to earlier under international standards the CEDAW Committee's Concluding Observations on the Sri Lanka report in 2002 expressed concern about this aspect of the criminalization of abortion.

3.3.3. State effort on laws, regulations, policies and implementation

Abortion is a criminal offence under 1883 Penal code section 303 except if performed to save the life of the mother. "Voluntarily causing a miscarriage" is an offence punishable with up to 3 years imprisonment and / or fine or up to 7 years of imprisonment if the woman is "quick with child." If the woman dies the conduct becomes a grave crime punishable with up to 20 years and a fine. The woman who permits the abortion also can be prosecuted for the crime.

The legal environment conflicts with Sri Lanka's commitments under human rights standards, a fact noted by several treaty bodies including the CEDAW Committee and referred to earlier, (168.) The legal provision also conflicts with the Constitutional guarantees on right to life and equality, since it is women who are affected adversely, and abortion

can also be a dimension of Gender Based Violence (GBV), if a woman is forced to terminate a pregnancy by an abusive spouse, partner or parent.

This is a type of strict liability because abortion is illegal unless it is done with the intention of saving the life of the mother. Terminating the pregnancy becomes legal if it is proved that this was done “in good faith for the purpose of saving the life of the woman.” Good faith is a general term defined in the Penal Code. “Life” is physical life but there is jurisprudence in English law (Re Bourne 1939 1 KB 687) that can be used to argue that this covers mental trauma that affects the woman.

The burden is on the prosecution to prove that the abortion was not to save the life of the mother. They will prove this by the circumstances and context. However any person who causes an abortion even to save the life of the mother will be liable to prosecution for the offence. The medical professional will be called upon to justify that the termination was to save the mother’s life.

During the course of last two decades the high incidence of illegal abortion and the adverse consequences have been discussed in public by many, including women’s groups, health professionals and lawyers. This has led to advocacy for reform of the law. Several attempts were made by different governments to change the law on abortion. In the first occasion, in late 1970s, a private member’s bill was brought to the parliament with the intention of legalizing abortion. It was unsuccessful due to pressure from religious groups.¹⁵⁷ In 1995, amendments to the Penal Code were proposed to reform the colonial law on sexual offences. One amendment dealt with legalizing abortion in instances of conception as a result of an act of rape or incest, or in which major fetal abnormalities were found. The provision in the bill included safeguards on the manner of performing the abortion and the consent that had to be obtained prior to terminating a pregnancy. Shortly before the Bill was presented to Parliament it was withdrawn, by the minister proposing amendments to the Penal Code. Once again changes to the law due to pressure from religious and other conservative groups.¹¹²

At present, there is an ongoing debate on the issue of abortion in Sri Lanka, and there is also wide disagreement as to the extent of legalization of abortion.

Private clinics that were known to be performing abortions for many years have been raided by the police in a recent initiative and some have been closed.

Despite evidence of the high incidence of abortion, successive governments and law reform commissions have been unwilling to address the need for reform of an area of law that is considered politically controversial, due to the anti abortion views expressed publicly by religious lobbies.

The Minister who withdrew provisions for reform after the legislation was presented in parliament in 1995 stated that health legislation would be brought to “decriminalize” abortion – but this has not been done. Professionals and women’s groups have consistently and over a long period raised the issue of the urgent need for law reform. Despite this and CEDAW Committee’s concluding Observations on the need to review the law there has been no initiatives on law reform.

The Government has only addressed the issue indirectly through various health policies.

Health master plan 2007-2016¹⁵² identifies unwanted pregnancies and abortions as issues that pose a significant challenge to the well being of adolescents but identifies only an indirect intervention, as a solution. It proposes developing their knowledge attitudes, values, skills & behaviors with respect to biological, psychological, socio cultural & reproductive dimensions of adolescence.

This approach seems to be the same as seen in **1998 in the Health Master**¹⁵² Plan where change of behavior was recommended specifically targeting the adolescents.

In the Draft Sri Lanka National Plan of Action for Women 2007 - 2012¹⁶⁹ The Ministry of Women’s Affairs responded and recognized

that an effort should be made to eliminate unsafe abortions by providing legal provisions for abortions in circumstances of rape, incest and fetal abnormality under the section on women and Health¹⁶⁹

The draft MCH Policy of 2008¹³⁹ recognizes the importance of Enabling all couples to have a desired number of children with optimal spacing to reduce unintended pregnancies as a policy and recognizes emerging issues regarding abortion such as the fact that induced abortion is a phenomenon that is increasingly seen within marriage, indicating that it is being used for spacing of births or for limiting family size, and recommends addressing the unmet need for contraception, and establishing an appropriate system for post-abortion care.

This is an encouraging step though small as for the first time establishing a mechanism to care for survivors of abortion is mentioned in a policy document of Ministry of Health.

The Health Master Plan¹⁵² also attempts to address the issue of teenage pregnancy in a very broad manner in the school health programme, by mentioning; “ensuring that children are healthy, capable of promoting their own health and health of the family and the community and are able to optimally benefit opportunities provided to obtain correct information and develop life skills to prevent reproductive health problems including teenage pregnancy, by promoting health service delivery” as a strategy .

3.3.4. Barriers in laws, regulations and policies

1. The Law in Sri Lanka is very restrictive and does not address the reality of a high incidence of illegal abortion and the resulting adverse health consequences for women.
2. The current law criminalizes the conduct of the woman who seeks or permits an abortion that is not considered legal, and places the responsibility of reporting illegal abortion with the medical professional.

3. Medical professionals who desire to perform medical termination in the interest of the patient can be inhibited in their decision making by the restrictive law.
4. (a) Although many health policies refer to the need of addressing unsafe abortion and promoting attitudinal change, encouraging access to contraception, the Ministry of Education is very resistant to even mentioning the word contraception in the education material used in schools.
(b) School teachers also lack understanding and gender sensitivity to be able to teach a curriculum which deals with contraception. This paradox shows the difficulties faced by the State in addressing the issue of abortion.
(c) The state is reluctant to address the issue of abortion in a context where the issue of abortion is perceived as controversial and politically sensitive.
(d) There is no clear mechanism to ensure the continuity of education of the school going adolescent who gets pregnant.
5. (a) There is only limited provision of emergency contraception in the family planning service package of the State health sector.
(b) There is no formal provision for offering emergency contraception in the legal and medical institutions which provides care to adolescents who suffer sexual violence ,although some institutions such as JMO Office Colombo provides it.
6. There is a lack of awareness among the public especially the religious lobbies of magnitude of the health consequences of unsafe abortion.
7. Although the national prevalence of contraceptive use is high there is an unmet need among adolescents who may get pregnant and resort to unsafe abortion.

3.3.5. Recommendations.

1. To advocate for a change of the law as a public health issue highlighting as an initial step decriminalization of abortion and providing for legal termination on specified grounds such as rape, incest and severe congenital abnormalities. This will address some of the negative implications of abortions for women and adolescents of Sri Lanka.

Responsible Authority: Professional Bodies/ NCW/NCPA

2. Reporting cases of abortion should be considered as an invasion of the woman's right to privacy. Changes to the law should be accompanied by a review of the health regulations and policies to incorporate the concept of a right of privacy. This will help to relieve the responsibility of the medical officers from reporting every possible abortion.

Responsible authority: MoH/ Ministry of Justice, Professional Bodies/ NCW/ NCPA

3. Guidelines should be developed for health and legal professionals and law enforcement agencies clarifying the meaning of the current exception, and any further exceptions. These guidelines will motivate and facilitate practitioners to perform legal abortions. That will also help to encourage prosecutions only with careful consideration of the circumstances in which medical termination has taken place.

Responsible authority: Ministry of Justice. MoH

4. (a) Sustained advocacy and work with Health and Education officials and professionals to encourage a review of the school curriculum to include the topic of contraception.
(b) Improve the quality of training of teachers to create attitudinal change to understand the importance of contraception.
(c) To advocate changes in Ministry of Health policies and regulations in order to enhance SRH educations in schools to include contraception.

- (d) To advocate changes in Ministry of Health policies to ensure that continuation of the education for pregnant adolescents as a basic human rights.

Responsible authority: MoH/ MoE/ NEC

5. (a) To strengthen Ministry of Health policies and regulations to include emergency contraception in the Ministry of Health contraception package and make it available to adolescents and youth.

- (b) To introduce practices that will ensure formal provision of emergency contraception's to victims of violence. Train and sensitize the law enforcement and health authorities' including JMO's to provide emergency contraceptives in the event of sexual violence to adolescents.

Responsible authority: MoH/ Forensic specialists/ Police training institutes

6. (a) Advocacy on abortion as a health issue to prevent a back tracking and withdrawal from the current legal position, permitting abortion even to "save the life of the mother".

Responsible authority: MoH/ Professional medical associations/ Women's groups/SLFPA

7. Conduct public meeting /campaigns on health and GBV dimensions of abortion so as to undermine religious lobbies that oppose changes to laws and policies related to including rape incest and congenital abnormalities compatible for life and create a supportive environment for reforms

Responsible authority: .MoH / HEB/ FHB Media Ministry,

3.4. Combating STIs including HIV

3.4.1. Health situation

3.4.1.1. Introduction

Nearly two decades after Sri Lanka reported its first case of HIV Infection; it still remains one of the few countries in the Region with a low HIV infection prevalence,¹⁷⁰ with an estimated less than 0.1 percent of the population carrying the virus.

Although Sri Lanka is considered a low prevalence country from the point of HIV/AIDS the incidence of other STIs is not low and in the year 2004, 30% of those who came in for treatment for STIs in the state sector clinics were below the age of 24 years with 28.7 in the 15-24 age group.¹²⁸

3.4.1.2. Prevalence

It is also documented that, STD prevalence is on the rise particularly among young people¹⁷¹

Table 11: ALL Sexually Transmitted Diseases by Age Group 2004

(Both venereal and non venereal)

Age group	Women		Men	
	No	% (of total no)	No	% (of total no)
0-14	305	4.4	163	2.1
15-24	2245	32.5	2264	28.7
Other Age Groups	4365	63.1	5471	69.2
Total	6915	100.0	7898	100

Source: (128)

Up to the year 2000, only 5 cases have been recorded among patients with HIV below the age of 19 yrs. A total of 28 cases have been reported out of a total of 358 of HIV in the 0-24 age group with HIV infection between years 1987-2000^{172, 130}

However by the year 2005 a total of 68 patients have been reported up to the age below 24 yrs.¹²⁸

A large number of young persons have the potential of acquiring HIV. Rising median age of marriage, increased opportunities for male female interaction in educational establishments and work places and the rapid changes in social and cultural norms particularly with increasing access to the media and internet, have contributed to the practice of irresponsible and high risk sexual behavior.¹⁷¹

3.4.1.3. Vulnerable Groups

Among adolescents and youth, who are considered vulnerable rather than a high risk group for HIV/AIDS in Sri Lanka, there are sub populations who are more at risk than others, such as young workers at the Free Trade Zone, Beach Boys and Girls involved in sex work and sex tourism¹⁷¹ Although the number of street children number less than 1000 in the main City Colombo, they remain a potentially vulnerable group.¹⁴⁶

The proportion of young sex workers is not known among the estimated sex workers. It is estimated that the number of young sex workers are continually increasing, because of deteriorating economic and social conditions¹⁷¹

Young boys may be more at risk of HIV than girls because studies on local/domestic environment have shown that prevalence of Child Abuse is relatively higher (approximately 20%) for boys than girls (10%). The higher proportion of foreign sex tourists accessing more boys may be related to this.^{143, 144, 145}

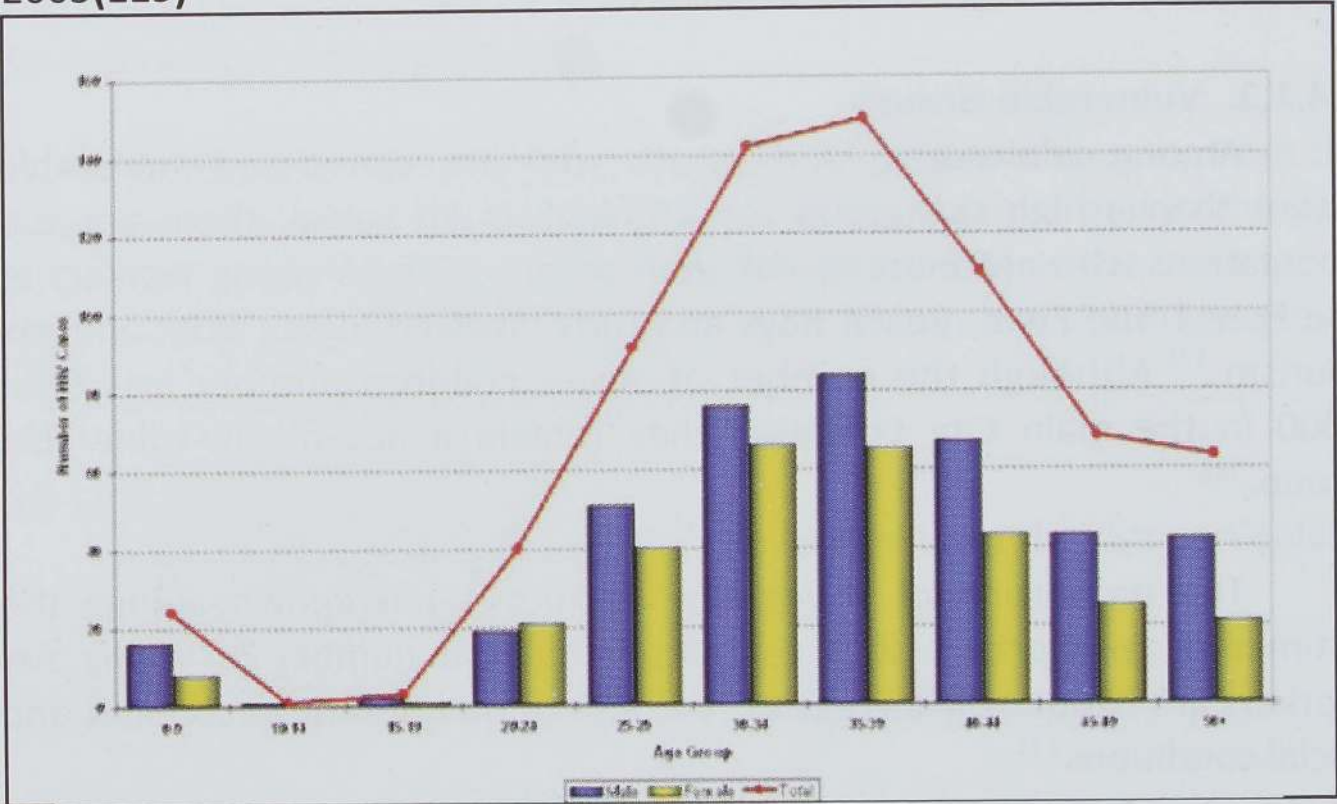
State action in introducing the National Child Protection Authority a statutory body (NCPA Act no 50 of 1998)¹⁷³ resulted in a campaign to crackdown on offenders both local and foreign and included undercover activity by NCPA. This led to some success in reducing the incidence of child sexual exploitation. Homosexuality is illegal in Sri Lanka as mentioned earlier and MSM is not apparent in the statistics. Only 11% of the reported HIV infections were due to homosexual relationships.¹⁷⁴ Health services are available without discrimination

The injecting Drug users are relatively less common in Sri Lanka and are estimated to be only around 2 % of the total 40,000 heroin users.

3.4.1.4. Gender Dimension in HIV/AIDS

The estimated prevalence of HIV/ AIDS among adolescents appears to be low.¹¹⁶

Figure 06: AGE distribution of HIV/AIDS in Sri Lanka At the end of 2005(119)

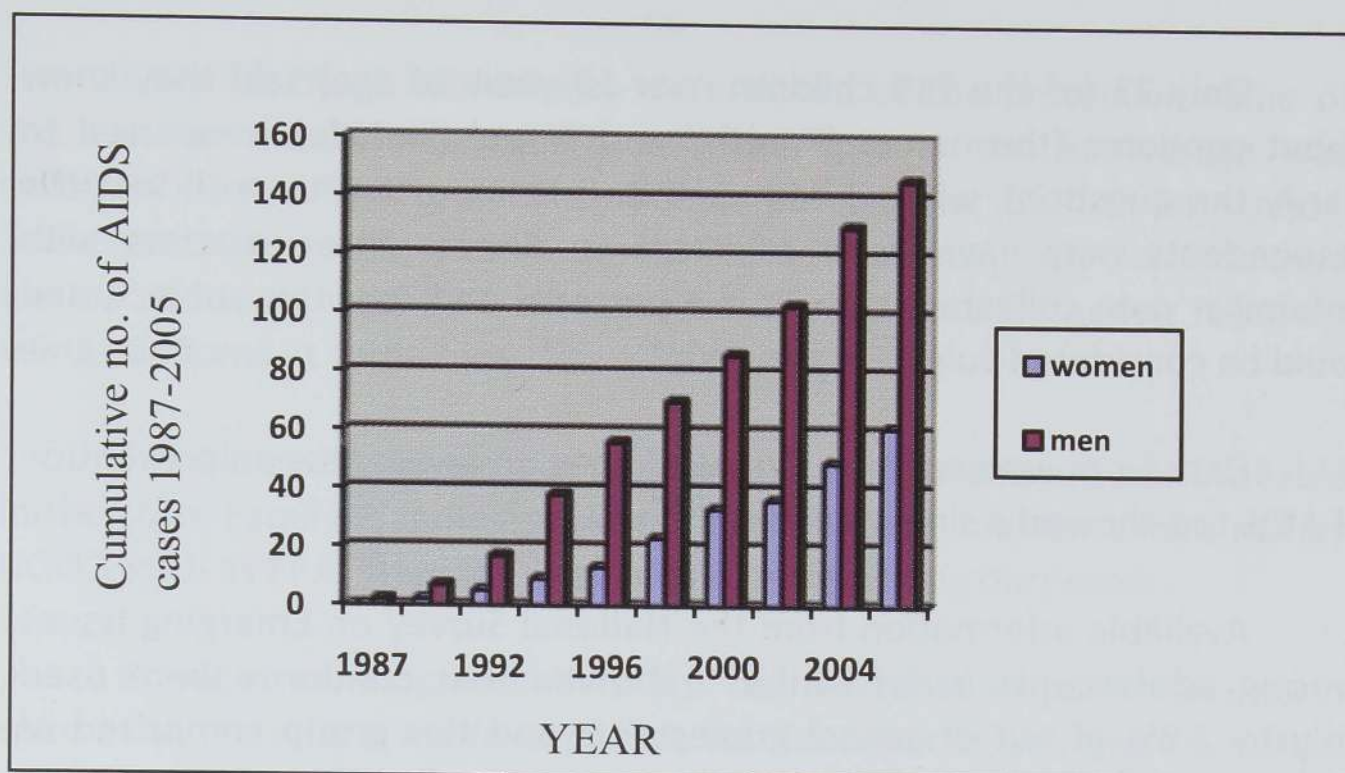


Source: (119)

*The infections among the females appear to be lower than among men when all ages are concerned.*¹²⁸

However when only the age group 15 -24 is considered there is a marginal increase in the incidence among females. The numbers are so small (16 females and 13 males) that the conclusion must be made with reservation.^{130, 172}

Figure 07: Cumulative number of AIDS cases 1987-2005.



Source: (128)

3.4.1.5. Knowledge amongst adolescents on preventing HIV

Knowledge on the methods of preventing HIV is important in addressing the issue, and this, among adolescents appears to be lacking. A National survey carried out among 29 911 adolescents inclusive of “school going” and “out of school” adolescents found that knowledge on correctly identifying ways of preventing HIV was not very high¹¹²

Table 12: knowledge of adolescents on correctly identifying ways of preventing HIV

Abstain from sex	Use condoms while having sex	Having only one faithful sexual partner who is not infected	Avoiding sex with homosexuals	Avoiding many sex partners	Avoid using unsterile needles/ syringes	N
33.9	25.8	29.1	17.9	25.1	17.6	19934

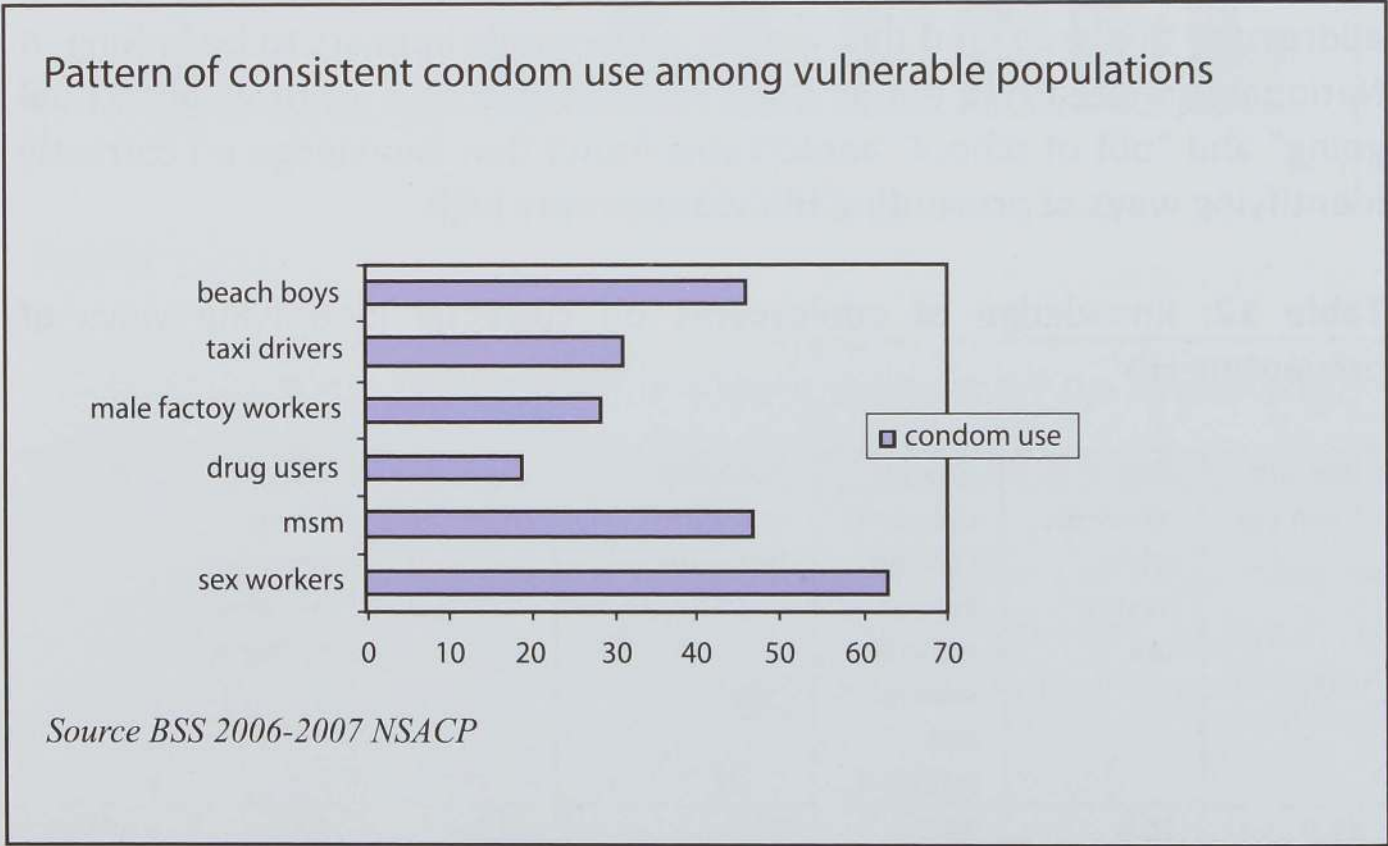
Source: (112)

Only 23 (of the 219 children over 10 years of age) said they knew about condoms (the names 'Preethi' and 'kopu' (Sinhala) were used to clarify the question), while 3 had used it. It is important to note that the respondents may have been reluctant to discuss these matters with unfamiliar data collectors since it is a personal and sensitive subject, and could be considered vulgar by society.¹⁴⁶

Data from women, inclusive of all ages on awareness on prevention of AIDS too showed a similar picture¹²⁸

Available information from the National Survey on Emerging Issues among adolescents in Sri Lanka¹¹² showed that condoms were used only by 2.8% of out of school adolescents and this group comprised of 91%, unmarried

Figure 08: Pattern on consistent use of condoms by vulnerable populations



Source: (175)

Lack of knowledge in ways of preventing HIV and other STIs among adolescents was also apparent in the study indicating the deficiency of SRH education.

Only 20.7% of adolescents were aware of the protective value of the condom in preventing STIs and this gap in the knowledge was reflected in the finding of the national survey that of “out of school” adolescents consisting of 91% unmarried adolescents, only 2.8% claimed use of condoms, and 39% of those who were sexually active reported using condoms at some time.¹¹²

Female condoms are not popular in Sri Lanka and are not available in the state Family Planning package. It is available in a few clinics run by NGO'S such as FPA. They are used mostly for teaching purposes.

Condom vending machines are not available in public places. In spite of all the efforts made to popularize the condom, still there is stigma associated with accessing condoms from shops without privacy. An adolescent particularly would therefore be reluctant to ask the shop keeper for a condom.

3.4.1.6. Knowledge of other aspects of HIV/AIDS

Questions on the knowledge of drugs and HIV were asked only from children over 10 years (N=219). 39 children were excluded, either because they were below the age of 11 years (33) or their ages were not recorded (6). Both the terms HIV and AIDS were used since the disease may be known by either term or both. 84 children had heard the term 'AIDS' while only 11 had heard the term 'HIV'.¹⁴⁶

Table 13: Knowledge on HIV/AIDS among street children
The responses were:

No Response	127
I don not know	033
It's a 'disease'	003
Dangerous/deadly/incurable disease	025
Transmitted disease	014
Transmitted by sex	007
Transmitted by females	001
Transmitted by foreigners	001
Transmitted by touching infected blood	001
Heard/knows through others	004
Heard/knows through TV	002
Heard/knows through news papers	001

Source: (146)

The results indicate a paucity of knowledge on HIV and AIDS as well as some false notions. This stresses the need for awareness creation for attitudinal change amongst this vulnerable population.¹⁴⁶

3.4.1.7. Screening of pregnant adolescents for Syphilis and HIV

The state antenatal care package offers testing for Syphilis for every pregnant mother free of charge. However age disaggregated data is not available to identify the coverage on adolescent pregnancies.

In the year 2007 of 149798 pregnant women of all ages whose blood was tested for Syphilis 662 were found to be reactive for VDRL but only 38 women were confirmed positive for syphilis¹¹⁹

Testing blood for HIV is not offered in the routine ANC package. Consent for testing blood for HIV is mandatory .Voluntary testing with pre test and post test counseling is available to any adolescent or youth in most of the clinics run in the hospitals although the numbers who opt for voluntary testing is very small.

HIV testing and counseling services are available free of charge at any of the STD clinics available throughout the country for any person including adolescents and youth.

Sri Lanka does not require mandatory blood testing for HIV on entering the country.

HIV testing could be obtained at all major hospitals with consent by sending the blood to the STD programme.¹⁷⁰

Of the 26 laboratories run by the NSACP (National STD/AIDS Control Programme) in peripheral areas offering HIV testing, 12 perform testing on site, 7 send samples to the National STD Reference Laboratory and seven send to another STI or hospital laboratory.¹⁷⁶

This facility is also available at most private hospitals and at clinics of some general practitioners with more privacy but the quality of the testing may not be uniform. In the private sector it is available at a cost of about Rs 300/= (Approx US \$ 2.5) The private laboratories are not necessarily monitored.

In the State sector the quality is assured by the central quality control laboratory and is provided free of charge. Although facilities are available, stigma attached to the HIV/AIDS makes it very difficult for an adolescent, particularly if unmarried to build up enough courage to access these services.

HIV prevalence among 15-24 y old age groups was estimated to be 0.02% among males and 0.03% among females by the year 2005.¹⁷⁷ Therefore it is difficult to comment on HIV testing behaviors of adolescents.

However a voluntary testing programme in antenatal clinics, within Colombo municipality was launched in 2000-2007 and the numbers who accepted the testing are given below. Unfortunately adolescents have not be identified separately and the numbers of positives are extremely low.

119

Table 14: Voluntary testing of HIV in ANC within Colombo municipality in 2000-2007

Year	Number Tested	Number positive	Percentage
2000	30906	3	0.01
2001	20409	0	0
2002	17601	0	0
2003	20286	1	0.01
2004	14529	2	0.01
2005	14476	0	0
2006	11485	0	0
2007	6543	1	0.01

Source: (119)

3.4.1.8. Treatment for HIV/AIDS

The State sector provides free ART (anti retroviral therapy) to any patient including adolescents and youth as well as ART for PMTCT (prevention of mother-to-child transmission) and drugs for management of complications free of charge from any state sector health institution. In the Clinics and service outlets of the NASCP, special emphasis is taken to maintain confidentiality. However there is anecdotal evidence that a breach of confidentiality sometimes occurred, resulting in stigmatization of the patient.

3.4.2. International and National Human Rights Standards

3.4.2.1. International Human Rights Standards

International standards on the right to life and health care, education and information are relevant to this issue.

CEDAW’s general article on human rights reinforces international standards on the right to life, personal security and freedom from violence even though these rights are not specifically stated in the Convention. Article 12 on the right to health and Article 10 on the right to education are also relevant to developing interventions that can impact on STIs and HIV/AIDS.

CRC's Article 6 on the right to life, Article 24 on the child's right to health and support for maternal health care, and Articles on education and the right to information and using mass media to promote child rights (Art 28, 13, 17) set standards that can be used in law and policy formulation in this area.

ICCPR has a corresponding article on the right to life, (Art 6) reinforced by the right to personal security (Art 9) Art 19 of ICCPR refers to the right to information, freedom of thought and opinion which are all relevant to this topic. ICESCR's Article on Health (Art 12) sets similar human rights standards. ICESCR's Articles on fostering scientific research and the right to education are also relevant [Art 13, 14 and 15 (1) (b)] as also the Article on the protection of the family and maternity. (Art 10). CERD's Article 5 (d) (iv and (v) on the right of access to public health, medical care and services and education harmonize with these human rights standards and are relevant in this area. CERD also recognizes the right to personal security against acts of infringement by State or Non State Actors (Art 5 (b)).

The above major human rights instruments also recognize rights of non-discrimination and equality, protection from sexual exploitation abuse and violence, and the right of privacy which provide a framework for law and policy reform to combat the underlying causes and manifestation of STI s and HIV AIDS.

CEDAW's Articles on equality in the relationship between husband and wife (Art 16), and removal of stereotypical attitudes to women in the family, (Art 5), encourage a response to eliminate harmful traditional or cultural practices that prevent effective responses to STI's and HIV AIDS. CEDAW's Article on the State obligation to prevent exploitation of women in prostitution and trafficking (Art 6), reinforce this standard. CRC's Articles on Non-discrimination (Art 2), protection of children from sexual exploitation (Art 19, 34 and 39) and elimination of harmful traditional practices (Art 24 (3)) can be considered corresponding standards that are relevant in relation to STIs and HIV AIDS prevention. ICCPR general articles on equality in spousal relationships (Art 26, 14 and 23 (4) are also relevant. The recognition of the right to privacy in ICCPR and CRC (Art 17 and 16) are relevant in this area, but would have to be balanced by the other

rights of spouses and parents on joint rights and responsibilities referred to in earlier sections.

The same balance is needed in interpreting cultural rights in the ICESCR and CRC – they cannot undermine the other human rights mentioned above or justify recognition of cultural practices that impinge on rights of equality and personal security. ICCPR's and ICESCR's Articles on protection of the family must also be interpreted so that other rights mentioned above are not undermined but harmonized.

CAT and ICCPR have articles on the right to freedom from torture and inhuman degrading treatment. These standards require laws and policies to protect individuals from harmful traditional practices and acts of abuse that can lead to STI and HIV transmission. [Art 7 ICCPR, CAT Art 1, 2, 16]

All these treaty bodies have used these standards to impose obligations on the State Parties to take action to prevent and combat STI and HIV AIDS. The Concluding Observations of the CEDAW Committee and the CRC Committee have often referred to this aspect. The CRC Committee has specifically referred to this aspect in considering Sri Lanka's report. The HRC and CERD Committees have referred to this aspect in their Concluding Observations on a few countries. The ICESCR Committee has given the issue priority in its Concluding observations in the article relating to health. [See CRC Committee Sri Lanka Report (2003) The Application of Human Rights to Reproductive and Sexual Health op.cit p 147 etc].

Several General Comments and Recommendations of these treaty bodies also deal with this issue, interpreting treaty standards as applicable to this area. An early General Recommendation No 15 of 1990 of the CEDAW Committee specifically deals with addressing the issue of discrimination against women and children in preventive strategies on HIV AIDS. CEDAW's General Recommendation No 24 also specifically requires State's parties to report regularly on preventing STI and HIV AIDS. It also refers to the need to give women and adolescent girls adequate information on preventive measures and treatment, identifying trafficked women, women exploited in prostitution and adolescent girls as

vulnerable groups that require special attention. Similarly, ICESCR's General Comment No 14 (2000) on the Right to the Highest Attainable Standard of health Care, refers specifically to the spread of HIV AIDS as a health hazard, and measures to combat HIV AIDS and STIs through preventive and education programmes, and medical care. This GR also addresses the issue of non-discrimination in treatment. The same specificity is seen in CRC General Comment No 3 (2003) on HIV and Children's Rights.

General Recommendation No 28 of 2000 of the HRC on Equality Rights between Men and Women has oblique references to this issue in referring to equality in relation to reproductive health and privacy. CEDAW's General Recommendations on VAW No 12 (1989) and No19 (1992), and General Recommendation No 14 (1990) on Female Circumcision and harmful traditional practices elaborate standards that are relevant to controlling STIs and HIV AIDS.

3.4.2.2. National Human Rights Standards

National Human Rights standards in Sri Lanka do not specifically address this issue. However the fundamental rights provision on equality and non-discrimination (Art 12,), freedom of speech and expression interpreted by the Supreme Court to include right to information (Art 14) freedom from torture and inhuman degrading treatment (Art 11) and the Directive Principle of State Policy on providing access to education (Art 27) set standards which harmonize with the international human rights norms and encourage measures to combat STIs and HIV AIDS. Discrimination against homosexuals and persons affected by HIV would also be covered by these standards though homosexuality is considered a criminal offence in the Penal Code.

The right to life, survival, health and education, and the right to information as indicated earlier by judicial interpretation and the right to equality and freedom from torture, may be considered aspects that encourage giving adolescents access to condoms to prevent HIV/AIDS and STIs. The right to manifestation of culture can, as pointed out earlier, be restricted by the State according to public interest, and therefore prevents recognition of culture as a restraint to law or policy formulation in this area. The right of access to education, recognized by judicial interpretation

of the right to equality in the Constitution prevents discrimination against HIV infected children in school admissions.

According to the Constitution, discrimination by State agencies can be challenged in Fundamental Rights cases. Jurisprudence in the Supreme Court as mentioned earlier has recognized that the State has an obligation to prevent discrimination by private agencies e.g. private hospitals. The State is therefore responsible for violation of the right to equality by inaction and failing to prevent discrimination.

As pointed out earlier, the right to privacy is recognized as an individual right in the law of civil liability and may regulate the area of patient confidentiality and voluntary testing of blood. However there is no general Constitutional guarantee of a right to privacy. The general criminal law on assault also means that person cannot be compelled to have his/her blood tested

Parental rights and responsibilities of child care and family support based on the Maintenance Act 1999 and jurisprudence, and other principles of English and Roman Dutch law facilitate the recognition of a legal responsibility for providing treatment, within the family. Parental rights and responsibilities can also mean that blood testing and right of privacy of an adolescent is subject to parental rights in the case of a child under the age of discretion. The child has independent decision making capacity after the age of discretion.¹⁰⁶

The ICCPR Act (2007) provisions on children's rights and access to basic services provisions in the Children's Charter (1993), and Women's Charter (1992) based on CEDAW and CRC respectively, encourage policy formulation and allocation of budgetary resources in this area, in conformity with international human rights standards.

3.4.3. State effort on laws, regulations, policies and implementation

As stated earlier the Constitutional guarantees on the right to information, equality and non discrimination and education provide remedies against State action and inaction in violating these rights. The importance of the right to information on HIV and STD is addressed in the National Draft HIV/AIDS policy under the heading promotion of safe and

responsible behavior where it is clearly stated that "The Government of Sri Lanka supports provision of preventive education and clinical services to those believed to be at high risk".¹⁷⁹

There is no specific law on HIV testing and counseling but the law on criminal assault in the Penal Code, and the Civil law on damages (tort in Anglo American law) prohibits taking of blood of an adult/youth without consent. Parental rights would extend to giving consent on behalf of children below the age of discretion which is 16 years

The consent of an adolescent male or female above this age will be recognized on the basis of their right to make independent decisions. There is no specific provision in the Evidence Ordinance of Sri Lanka that addresses the issue of blood test evidence. But this type of evidence is led under other provisions of the Evidence Ordinance and is accepted in court proceedings.

3.4.3.1. Homosexuality

Homosexual acts are illegal in Sri Lanka and criminalized in the Penal code in relation to same sex relations between men and women. A proposal to decriminalize adult homosexuality in the Penal Code reforms of 1995 failed and was not incorporated in the Act. Homosexual acts in public or private were criminal between males originally. In 1995 when the Penal Code was amended gender neutral language ("person") was used in defining the offence of homosexuality. The offence now covers female homosexuality.

Section 365A of the Amendment to the Penal Code 1995 states that " Any person who, in public or private, commits, or is a party to the commission of , or procures or attempts to procure the commission by any person of any act of gross indecency with another person, shall be guilty of an offence and shall be punished with imprisonment of either description for a term which may extend to two years or with a fine, or with both and where the offence is committed by a person over eighteen (18) years of age in respect of any person under sixteen (16) years of age shall be punished with rigorous imprisonment for a term not less than 10 years and not exceeding 20 years and with a fine and shall also be ordered to pay compensation of amount determined by court to the person in

respect of whom the offence was committed for the injuries caused to such a person”.

Though homosexuality is a criminal offence, there are no prosecutions, except in the case of adult males who have been prosecuted for homosexual acts with boys under 16 years, as child abuse. An amendment of 1998 recognized that the age of consent is 16 years, in the case of the offence of Grave Sexual Abuse introduced by the Penal Code amendment 1995. This means that the consent of a girl or a boy above 16 yrs is a defence to a prosecution for grave sexual abuse. This 1998 provision accepts a concept of an age of sexual consent of 16 years in regard to homosexual acts and therefore states a different policy from the provision criminalizing homosexuality.

Adolescents who are homosexual have access to health services in both State and private institutions without discrimination in practice. Since access to education is a constitutionally guaranteed right, they cannot be denied access to state or private schools. Such acts can be challenged in a fundamental rights action.

The Government of Sri Lanka recognized the importance of the control of STIs as early as 1921 by the initiation of ‘Venereal Disease Control Programme’, by the then Colonial Government, which was later upgraded as the Anti Venereal Disease Campaign in 1952. Thereafter, an HIV/AIDS control programme was integrated in to it, and the National Sexually Transmitted Diseases and AIDS control Programme, as it is known at present came in to being.¹⁷⁸

The Programme began as a dominantly clinical service, but has evolved into a multi sectoral collaborative programme that aims at combining different strategies in order to keep the prevalence of STD and HIV infection low in the country. The clinical services are delivered through a network of 29 full time clinics and three branch clinics throughout the island, in addition to the national reference laboratory service in Colombo,

The Draft national HIV/AIDS Policy categorically states that “The use of condoms is of utmost importance for the high risk and key vulnerable target populations and should be promoted”.

The government initiated an External Review by international experts, which in its recommendations reiterated the need of implementation of the previous strategy by stating “Condom programmes should be introduced through social marketing and structured interventions. Condom programmes of 100% coverage (for specific vulnerable groups) should be strengthened, where possible”.¹⁷⁰

3.4.3.2. Testing and Counseling for HIV

High priority has been given for discussion on HIV testing and counseling by the Government of Sri Lanka in the Draft HIV/AIDS Policy **(179)**. The Policy concurs with promoting voluntary confidential testing, recognizing that mandatory testing would drive those at high risk of HIV infection beyond reach and prevent their access to public health preventive activities and other health services.

The National HIV/AIDS Strategic plan 2007-2011¹⁷⁴ under the Guiding principle “Respect for human Rights” states that “HIV testing without prior informed consent is never acceptable (unless anonymous unlinked for screening purposes) and each HIV test result has to be confidential”.

Review of the national response to STIs and HIV/AIDS in Sri Lanka **(170)** clearly states that Key factors in voluntary testing include “ensuring an ethical process for conducting the testing, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information”.

The Draft HIV/AIDS Policy¹⁷⁹ recognizes, though not specifically for adolescents, that Counseling as an integral part of programs related to HIV/AIDS prevention, care and treatment. It states that “It is important that these services are provided by persons who are adequately trained in HIV/AIDS counseling.”

National counseling guidelines were developed in 2003.

A senior venereologist has been appointed as the Counseling Coordinator in the national programme to carry out all coordination and integration efforts under the management of the NSACP.

The National HIV/AIDS Strategic plan 2007-2011¹⁷⁴ the importance of increased quality and use of Voluntary Confidential Counseling and Testing (VCCT) services is highlighted

3.4.3.3. Treatment of HIV/AIDS

Although there is no specific law on treatment, the law on parental responsibilities as contained in the law on custody, guardianship, and maintenance of an adolescent, clarifies that there is a duty to provide treatment and care.

The Draft National HIV/AIDS Policy¹⁷⁹ clearly provides for treatment for HIV/AIDS for any citizen. No special group as adolescents have been identified The Policy under the topic care and treatment of HIV/AIDS says "The Government of Sri Lanka accepts the rights of those living with HIV/AIDS to have access to treatment without stigma and discrimination. Persons living with HIV/AIDS requiring antiretroviral treatment and management of opportunistic infections will be provided such services by the State sector in line with national guidelines and prevailing National health policy"

In 1998, the Ministry of Health and Nutrition issued a circular instructing all health facilities to offer care to patients living with HIV/AIDS without the use of separate wards. As the number of people diagnosed with HIV has remained very low, most health facilities have had only sporadic involvement in the provision of care for PLHA.¹⁷⁰

A milestone in provision of care is the public sector access to ART free of charge in 2004. Use of ART in prevention of PMTC is included in the Antenatal care package and is provided free of charge.

There has been little provision of HIV care in the private sector to date, and often private institutions discourage the patients from coming

for treatment owing to the stigma attached to HIV/AIDS. The review of the national response to sexually transmitted infections and HIV/AIDS in Sri Lanka identified that no government policy or guideline exists on provision of HIV care privately.

3.4.3.4. PMTCT (prevention of mother-to-child transmission)

The Draft Policy on HIV /AIDS¹⁷⁹ in its' objectives, has recognized prevention of mother to child transmission as a major objective, although no specific provision for adolescents is available

Sri Lanka has adopted the comprehensive four-pronged PMTCT strategy, which includes primary prevention for women of childbearing age, prevention of unwanted pregnancy among HIV-infected women, interventions to reduce PMTCT, and provision of care and support to HIV-infected women, their children and family members.

Sri Lanka has developed PMTCT protocols, guidelines and has registered paediatric ARV drugs (syrups) and regimens in place. A PMTCT working group has been established and is functioning. A senior venereologist has been appointed as PMTCT Coordinator in the national programme.

3.4.3.5. Knowledge of adolescents on prevention of STIs other than HIV/AIDS

As discussed the Constitution guarantees the right to equality and non discrimination and education and information. These rights are reflected in policy documents. As early as 1952 The Health Act recognized that the "dissemination of health information as the duty of the state"

The Population and Reproductive Health policy the Goal vii **(138)** identifies that increase of public awareness of reproductive health issues including publishing and dissemination of updated information as an important goal to achieve

The National Policy on Health of Young Persons¹⁵¹ which is being developed addresses this issue more specifically by stating "it aims to provide the fulfillment of their needs including the protection and the promotion of their right to health minimizing the risk of ill health,

development of basic life skills, ensuring access to information and services and the creation of an enabling supportive environment”

This Policy addresses human rights issues and states that there is a right to access knowledge about HIV/AIDS/STI related issues and safer sexual practice.

3.4.3.6. Prevention and Treatment of STIs other than HIV/AIDS

There is no specific legislation regarding STIs but the law on parental responsibilities as contained in the law on custody, guardianship, and maintenance of an adolescent discussed, clarifies that there is a duty to provide treatment and care. Legal provisions on “age of discretion” and restricted parental rights can also help to determine issues regarding an adolescent’s right of privacy and right to independent decision making in treatment.

Although taking preventive measures comes within the purview of the policies on STIs, HPV vaccine has not been included in the state immunization package, and is still not available in the private sector.

3.4.3.7. Right to education for adolescents living with HIV/AIDS

As pointed out the state is obliged by the Compulsory Education Regulation 1997 adopted under the Education Ordinance to provide access to compulsory education (from 5 yrs up to 14 years) The Constitutionally guaranteed fundamental right to education and non-discrimination and the right to information recognize adolescents rights regarding education despite their HIV/AIDS status.

The Draft National HIV/AIDS Policy reiterates that “The Government of Sri Lanka recognizes that people living with HIV/AIDS are entitled to enjoyment of their fundamental human rights and freedom without any unjustified restrictions. These include the rights of everyone to life the right to education, the right to information which includes the right to knowledge about HIV/ AIDS / STIs related issues and safer sexual practices, the right to participate in the cultural life of the community and to share in scientific advancement and its benefits”. In principle these laws and policies ensure access to education

There is no law/regulation/policy that deals with expulsion of adolescents living with HIV/AIDS from school. Expulsion would conflict with the right of access to education and non-discrimination and can be challenged in the courts for infringement of fundamental rights and violation of the regulation on compulsory education.

National HIV/AIDS National Strategic Plan tries to address this issue by commissioning a segmented, multimedia campaign to reduce stigma and discrimination around HIV in families, Schools and the health sector.

3.4.3.8. Other Programmes on Prevention of HIV/AIDS

There are 21 State run, Youth Friendly health centers under the Ministry of Health. Youth Friendly Health Service is being conducted in the hospital OPD for adolescents and youth. It provides information on sexual health and HIV/AIDS and condom promotion and distribution is incorporated into the programme. Counseling services are available. Linkages are established with STD services.

Different government and para Statal agencies that work with adolescents and youth have undertaken significant HIV awareness work through extracurricular activities in schools. Among the agencies is the National Youth Services Council (With 171106 members in 4994 youth clubs), the Plantation Human Development Fund, and many NGOs. The focus of the work has been on general awareness-raising among adolescents and young people at the district level. Led by the MO-STI of the National Programme, the campaign uses skills-based approaches and peer leaders.

3.4.3.9. Allocation of resources

The ICCPR Act 2007 s.6 (1) (b) now³ states that every citizen has a right and opportunity to access services provided to the public by the state. Since the State for many decades provided free health services to the public, it may now be argued that citizen have a legal right to basic health services. Providing state health care necessarily requires allocation of resources.

3.4.4. Barriers in laws, regulations and policies

1. Although different policies and the strategies planned, attempt to address most of the issues related to prevention and management of HIV/AIDS, adolescents have not been identified as a distinct group.
2. There is a failure to recognize adolescents as a group with rights including privacy and confidentiality. They should be identified as a group with different needs and sensitivities in the **delivery of services**. They require encouragement, privacy and confidentiality which should be visible to them since they may not be able to access service with or without informing their parents
3. Data collection on HIV often is not disaggregated for adolescents which prevents action oriented programmes for adolescents
4. The allocation of resources monetary, physical and personnel is grossly inadequate for counseling services. The expertise available for counseling is inadequate both in quantity and quality.
5. Non availability of HPV vaccine in Sri Lanka especially to vulnerable and at risk groups of adolescents.
6. (a) Lack of awareness of **policy makers** on the importance of HIV/STI in SRH education targeting adolescents.
(b) Reluctance of the most members of the **teaching profession** to deal with issues of sex, sexual health HIV/STI in the classroom, despite the subjects being included in the syllabus
(c) The lack of knowledge among adolescents in spite of the awareness activities conducted by the state as well as by NGOs
7. Circulars and Standard Operative Procedures do not address the issue of consent for taking blood for testing for STIs, HIV, and the concept of age of discretion has not been incorporated. However In the case of a child under 18 years in practice, parental or guardian's consent will be considered necessary. There is lack of awareness that consent of an adolescent above the age of discretion is required.

8. Lack of clear understanding of the legal situation is evident from the anecdotal information that women sex workers are taken for mandatory testing by police, even though their consent is required by law.
9. The responsibility and procedure of informing parents or partner in the case of HIV/STI infection in an adolescent is not clearly defined.
10. There has been little provision of HIV care in the private sector to date and it is often discouraged by these institutions. If private sector facilities are offered there is no assurance that they are of high quality.
11. Lack of awareness of the disease, human rights perspectives and social responsibility leads to negative attitudes and behavior in relation to STI's and HIV.
12. Female condoms are not available in the State Family Planning package.
13. Condom vending machines are not available in public places. An adolescent particularly would therefore be reluctant to ask the shop keeper for a condom.
14. Some Police Officers patrolling the streets consider the possession of a condom by a girl as incriminating evidence of prostitution. Although this is not admissible as evidence in the courts of law, in a prosecution under the Vagrants Ordinance for street prostitution, this practice discourages using condoms for safe sex.
15. Stereotypical cultural attitudes to adolescent sexuality are a powerful disincentive to law making, policy formulation and implementation to combat HIV/AIDS and STIs. This is possibly the reason why there is no legislation on HIV/AIDS, and the reluctance to provide access to information through the education system. The concept of parental rights also prevents declaration of a clear legal right of adolescents to access contraceptive services and information.

16. The situation in some hospitals may not be satisfactory when patients with HIV/AIDS are admitted for in-patient care. Confidentiality may be broken – sometimes by staff, particularly the lower level employees. There are reports of instances where the patients have been moved to separate rooms and the information leaked even to their villages with disastrous consequences.¹⁸⁰

3.4.5. Recommendations

1. The existing and drafted policies have addressed many issues related to adolescents, though not specified categorically for them; the methodologies must be focused on adolescents and be designed to ensure that adolescents are not left behind at operational level when implementing policies.

Responsible authorities: MoH/ NSACP

2. The HIV services and clinics should recognize adolescents as a separate, sensitive group that may be reluctant to access to services. Changes to delivery of services in an innocuous manner would encourage acceptance.

Responsible authorities: STI programme of MoH/ MoH

3. Data collection methodologies and formats should be improved to identify ways to address the issues relevant to ASRH

Responsible authority: STI programme of MoH/ MoH

4. The State sector should recognize the importance of giving access to quality counseling services to adolescents and provide resources for these needs.

Responsible authority: MoH

5. As a service to the present generation of adolescents availability of HPV vaccine has to be considered as a way of preventing future cancer of cervix.

Responsible authority: MoH

6. (a) Advocacy at the highest policy making levels to recognize the importance of ASRH education as a crosscutting issue for all the components in this report. There should be an institutionalized linkage in health and education sectors to deal with ASRH issues.

(b) Advocacy and Education targeting the parents and teachers probably together to sensitize them regarding the adolescent's right to information, age of discretion and sexual consent, informed consent and the best interests of the child and the value of SRH in protecting the next generation from HIV and STIs. This will serve as an initial step in order to implement the policies already in place.

(c) Although at policy level SRH education is in place, it is ineffective at operational level. The teaching methodologies need to be reviewed to identify the challenges faced by the teachers at the point of delivery and strengthen them by identifying ways of communicating in a culturally sensitive manner.

(d) Current and new programmes for youth on vocational training, alcohol and drug abuse should integrate awareness on HIV/AIDS prevention and sexual responsibility.

Responsible authority: MoH(FHB, HEB, NSACP)/ MoE(NIE, Teacher Training Colleges)/ Faculties of Education of Universities/ Vocational training institutes/ NGO's addressing alcohol and drug abuse, child abuse/ Child rights groups/Women's groups/ MWA/ N/SC, relevant NGO's/ NCPA/ Ministry of Child Development and Womens Empowerment/ National Youth Council, Service clubs of Youth e.g. Rotary, Lions

7. Circulars and procedures should address consent for HIV testing over the age of discretion. The age at which parental consent is necessary (e.g.: below the age of discretion) should be clarified and the instructions should stipulate the requirement.

Responsible authority: MoH / Ministry of Justice

8. The issue of notification and circumstances in which mandatory testing should be permitted for HIV/AIDS or STIs must be raised, discussed and a clear position stated in law and policy followed by a

campaign of public awareness raising. The Evidence Ordinance should be amended to include a specific provision on blood test evidence.

Responsible authority: MoH /Ministry of Justice

9. The responsibility of health authorities to inform parents/ partner of HIV infection in adolescents has to be carefully considered and the process involved has to be clearly defined in policy and health workers education.

Responsible authority: MoH/ Ministry of Justice

10. The private sector should be encouraged to care for HIV patients and the government may have to consider imposing a legal obligation to do so. However, the care givers should be adequately trained and proper resources must be ensured. The facilities should include ARV drugs.

Responsible authority: Private medical health institutions/ Professional medical bodies/ MoH/ Ministry of Justice

11. Education regulations should ensure that HIV infected adolescents should remain in public or private schools. Awareness campaigns targeting school authorities including teachers as well as students highlighting the disease health and human rights aspects and social responsibility should be given priority.

Responsible authority: MoE/NEC/ University Faculties of Education/ Professional educational and medical associations.

12. The female condom and its use must be popularized in the State family planning package for the general public. The need to make available the female condom and promote social acceptance would have to be specifically addressed.

Responsible authority: MoH/ SLFPA.

13. The state and the NGO sector should undertake advocacy on acceptance of condom vending machines and help to create an environment supportive of installing them in identified locations which are socially acceptable.

Responsible authority: STI programme/ MoH

14. The Police Department should introduce guidelines prohibiting practices that lead to the arrest of girls in possession of condoms.
Responsible authority: Police Department/ Attorney Generals Department
15. Public advocacy and awareness raising programmes using print, audiovisual and web in the community and among all State agencies especially health and educational sectors to prevent discrimination is important. Education and awareness programmes for the general population should focus more on reducing stigma and discrimination against PLHA (people living with HIV/AIDS). In this regard, specified programmes should be conducted with police and other groups to produce an enabling environment for targeted interventions among FSWs, MSM and IDUs.¹⁷⁶
Responsible authority: State and private Media/ MoH/ MoE/ Ministry of Social Services/ Professional associations/ Medical and education/ NGO's including women's and child rights groups
16. Strict guidelines and codes of practice should be developed on maintaining confidentiality in State and private health institutions, to make health workers accountable in instances where confidentiality is breached.
Responsible authority: MoH / Ministry of Justice/ Private Health institution management bodies.

3.5. Promoting sexual health, addressing sexual violence, FGM and other harmful practices

3.5.1. Health situation

3.5.1.1. Introduction

The term sexual health is understood as the experience of the ongoing process of physical, psychological and socio-cultural well being, related to sexuality .Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life.¹⁸¹ This is all the more important in youth and adolescents but unfortunately least recognized, in contrast to other health concerns. Societal norms tend to consider sexuality as an adult right, particularly of married couples rather than adolescents. Policy makers have been reluctant to address sexual issues connected with adolescents directly. For sexual health to be promoted, attained and maintained it is necessary that problems, needs of adolescents and youth regarding sexuality be recognized and their RH rights ensured.

3.5.1.2. Sexual activity among adolescents

Although social values in all communities in Sri Lankan society discourage premarital sex, sexual activity among adolescents is not uncommon. A study among advanced level students (University entrance) in 1998 found that a relatively large proportion of them were engaged in some form of sexual activity.

Table 15: Sexual activity among advanced level students in 1998

Type of sexual activity	Male n=191 %	Female n=255 %
Intercourse	11.5	2.7
Anal Sex	12.6	-
Oral Sex	20.9	7.5
Inter-femoral	31.9	3.5
Other forms	42.9	27.8

Source: (156)

A national survey on adolescents mostly comprising of unmarried adolescents, found that 13.9% of boys and 2.2 % of girls have had sex during adolescence and the mean age at first sexual intercourse was 15.3years for males and 14.4 for females¹¹² Of the males who had a sexual experience, 18.2% were homosexual experiences and of females who had a sexual experience 3.2% were homosexual experiences.¹¹²

These realities contrast sharply with the current law on the legal age of consent for sexual intercourse. This is 16 years for both girls and boys under Sri Lankan law, with the exception of Muslim Law. (See later State action).

There has been recent, very strong anecdotal evidence of pressure for early marriage of girls in areas affected by the conflict. Parents and elders see early marriage as the only option for young girls in a situation where there can be a forced conscription by non State armed groups, and there is also disruption of education.

Table 16: Preference of sexual intercourse among adolescent in Sri Lanka 2004

Prevalence of sexual intercourse among adolescents in Sri Lanka, 2004				
	Schoolgoing adolescents			Out-of-school adolescents
	male	Female	All	
% who had friends having heterosexual relationship	40.1	10.7	20.5	NA
% who ever had heterosexual relationship	13.9	2.2	6.12	2.2
% who had heterosexual relations	18.2	3.6	10.2	9.3
Source: National survey on emerging issues among adolescents in Sri Lanka: UNICEF 2004 (10-19-year age group).				

Source: (112)

In another study among A’ level (university entrance) students, heterosexual sex was the most common preference among those who responded.

Table 17: Sexual preference among A/L students (182)

	Male (%)	Female (%)
Heterosexual	321 (68.4)	18 (7.8)
Homosexual	-	1 (0.4)
Bisexual	3 (0.6)	-
‘No one’	49 (10.4)	95 (41.3)
‘Do not know’	24 (5.1)	45 (19.6)
Did not respond	72 (15.4)	71 (30.9)

Table 18: Preferred sexual act

	Male (%)	Female (%)
Vaginal intercourse	219 (46.7)	4 (1.7)
Oral sex	111 (23.7)	4 (1.7)
Anal sex	62 (13.2)	0
Intercrural sex	75 (16.0)	0
Touching others genitals	157 (33.5)	1 (0.4)
Others fondling you	60 (8.6)	0

Table 19: Sexual behavior(experience)

	Male (%)	Female (%)
Sexual intercourse	9 (4.7%)	-
Anal sex	1	1
Oral sex	10 (5.2%)	4 (1.7%)
Inter-crural sex	4 (2.1%)	-
Fondling	6 (3.1%)	2 (0.9%)
Pornography	72 (37.3%)	2 (0.9%)
Masturbation	88 (45.6%)	2 (0.9%)

It was interesting that though students had a sexual preference, and a preferred sexual act, this was not indicated in their sexual behavior probably indicating fear of divulgence of information. For example 23.7% and 13.2% of males preferred oral and anal sex respectively but did not indicate the same in their behavior.¹⁸²

The knowledge on conception and pregnancy among adolescents in Sri Lanka appears to be relatively low. In the National Survey among adolescents the fact that conception was possible as a result of a single act of sexual intercourse was known only to 46% of the respondents, only 36% knew that there was a specific period in the menstrual cycle during which a woman could get pregnant, and just 17% could identify the fertile period correctly. Surprisingly more males than females were aware of the fertile period and could identify it correctly¹¹²

This indicates the need of strengthening the SRH education possibly as a part of school education.

3.5.1.3. Service delivery for adolescents

There are some adolescent sexual health services but coverage is limited. Some services are provided to adolescents and youth by the Ministry of Health and are coordinated by the Director Youth, Elderly and Disabled.

Additional services are provided by a separate ministry under the portfolio of Minister of Youth Affairs.

There are 21 State run Youth Friendly health centers under the Ministry of Health and some are attached to the health institutions.

In addition to the State service delivery mechanisms, there are many NGOs which are involved in service delivery for adolescents. Family Planning Association of Sri Lanka is one of the key organizations which conduct many advocacy and capacity building programmes, in addition to providing a counseling center Alokaya ,which adolescents can access free of charge.

Sarvodaya is another well known NGO which provides island wide coverage through their branch organizations providing similar services to adolescents. Recently an intervention of strengthening life skills for positive health behavior was conducted targeting the adolescents and youth of the urban under privileged / slum areas.

Different Governmental and Non Governmental agencies that work with adolescents and youth have undertaken significant health education work through extracurricular activities in schools.

The exact number of health care providers trained in youth friendly service provision is not known but adolescent health is in the curricula of all categories of health care providers and in service training programmes are conducted by the Family Health Bureau, which has appointed a consultant community physician as the focal point for school children and adolescent activities.

The Diploma in Reproductive Health Course conducted by the Post Graduate Institute of Medicine course has a module designated for ASRH.

3.5.1.4. Sexual Orientation

Homosexuality is illegal in Sri Lanka. In recent years there have been active lobbies advocating for changes in the law to decriminalize adult homosexuality. Proposals were made in 1995 earlier to decriminalize adult homosexuality. However they were nor accepted by the government, and as noted the Penal Code reforms broadened the offence to include females. There have been no official efforts to change the law in recent years but as pointed out the law is not enforced. General sexual health services to adolescents are available irrespective of their sexual orientation.

3.5.1.5. Sexual Violence

Accurate national data on sexual violence, specifically on adolescents is difficult to come by. However information from the Women’ and Children’s Bureau gives an idea of the magnitude of the problem.

Table 20: Severe offences* against children 2000-2008

	2000	2001	2002	2003	2005	2006	2007	2008 (Jan-Jun)
Murder	44	51	60	43	35	48	44	22
Attempted murder	20	17	16	8	12	13	32	6
Grievous hurt	56	56	46	128	88	80	45	28
Procuration					14	14	14	15
Sexual Exploitation	29	23	22	4	46	59	44	12
Abduction	301	329	357	387	191	186	125	49
Kidnapping					315	351	406	190
Rape	608	684	714	753	793	799	805	431

Trafficking					0	0	5	0
Unnatural offences	221	393	458	573	24	19	16	6
Grave sexual abuse					531	498	512	241
Incest	10	26	24	6	53	24	15	7
cruelty					136	94	120	51
Gross Indecency					16	17	19	9
Attempted Incest					6	3	2	0
Total					2260	2205	2204	1067

Source: (185)* (This refers to grave offences according to the criminal law)

The National Child Protection Authority of Sri Lanka citing the research of Prof. Harendra de Silva the Former Chairman states, based on a Southern province study sample of 1709, approximately 20% of boys and 10% of girls are sexually abused in Sri Lanka.^{186, 187}

A study in UNICEF 2005, (186) reported that sexual abuse among adolescents aged 10-13 years was 10% (14% for boys; 8% for girls).

The same study found that among 14-19 year olds, 14% have been sexually abused with little difference among boys and girls. (186)

A cross sectional study done using 230 girls and 469 boys revealed that 107(46.7%) girls and 366(78%) boys were victims of physical abuse out of which 6 (2.6%) girls and 27(5.8) boys were victims of sexual abuse during their childhood¹⁸⁸

National data specifically on adolescents are not available.

A medical professional is required to report all cases of sexual violence including child abuse because these are criminal offences under

the Penal Code. Services for victims of sexual violence are free of charge in State hospitals. Medical treatment and forensic examination by a Judicial Medical Officer (JMO) is available at all these institutions. In the higher level hospitals (District General, Provincial general and Teaching) the services of a specialist Judicial Medical Officer (Forensic pathologist) may also be available. They provide emergency medical services to victims including emergency contraception. However there is a deficit in providing counseling services in these State hospitals, as trained counselors are not available except in a few of them. NGOs including a women's group addressing violence against women (Women In Need (WIN)) support the Ministry of Health in providing counseling at some major hospitals. The health ministry has no cadre for psychologists in government hospitals and there are only a limited number of psychiatrists in the country. The workload of psychiatrists is extensive and they are unable to provide counseling services for adolescents.

3.5.1.6. Trafficking in Children and Adolescents

Children below the legal age of employment (14 years) who work in the informal sector particularly in domestic service are invariably trafficked into employment. These children are deprived of a range of children rights and are at risk of sexual abuse.

In Sri Lanka, although industrial exploitation of children is not as much of a problem as it is in other countries in the region, domestic employment of children was a major problem. Many Sri Lankans including professionals were employing child servants. The trend of poor Sri Lankan women seeking employment in the Middle East as housemaids, the demand for high wages for domestic help, and the high cost of feeding an adult have made it difficult and expensive to recruit such help for Sri Lankan households. These conditions probably contributed to an increase in domestic employment of children, as children are paid low salaries (if any) and demand less of their employers in terms of food and basic human rights. A concerted public campaign by the NCPA has resulted in lowering the incidence and virtually eliminating it in some metropolitan areas. A study in 1997 of almost 700 households in urban areas in the South indicates that 1 in 12 houses has a child servant, and 1/3rd of the domestic labor force consisted of children (de Silva, 1997). This was a more significant problem in the plantation sector where children comprised as

much as 44% of the domestic labor force. Professionals, including doctors, businessmen and landowners were the main perpetrators. A follow-up study showed that most of these children were from unstable tea plantation worker families. (De Silva, 1997)^{187, 190} CENWOR 2005. The IDP situation of all communities in the zones affected by internal conflict, especially the East, has also compounded this problem. In addition to being forced to perform hard physical labor, most of these children are physically abused. They are often sexually abused and almost always emotionally abused. In addition, many of these children are deprived of schooling and nutrition as well.

3.5.1.7. Commercial Sexual Exploitation

Although commercial sexual exploitation of boys (often referred to as “boy prostitution”) was known to the sexually transmitted diseases control program in 1965, this exploitation catered to only a few local people (Arulanantham, 1992). However, the 70s and 80s brought an explosion in tourism. At the same time emerged a problem of sexual abuse by the pedophile tourist resorts. Early reports documenting the abuse were prepared by non-governmental organizations (NGOs) or sociologists and presented at professional meetings, but they were not well documented, and there were no supporting reports in the medical literature.

International Magazines such as “Spartucus International Gay Guide,” produced in the Netherlands and Germany, achieved particular notoriety for promoting certain countries such as Sri Lanka, Philippines, and Thailand for homosexual tourism, and highlighting the availability of children at these destinations (Spartucus International Gay Guide, 1995-1996).

In 1980, Tim Bond published a well-documented report (Bond, 1980), which identified Sri Lanka as second only to the Philippines as a source for “cheap child sex.” This report highlighted the demand for boys, starting as young as 8 years, while citing poverty, orphans, and broken homes as factors contributing to the exploitation. Bond estimated the number of commercially exploited boys in Sri Lanka in 1980 to be around 2000. (Sri Lanka’s total child population is around 4.2 million).

Many NGOs cited sometimes-conflicting numbers of children commercially exploited for sex with the quoted figures ranging as high as 30,000. Ratnapala (1999) and sociological studies done in the early nineties found 926 child sex workers under 16 years of age, and 533 younger than 18 years of age in the tourist areas of the country.

The 1995/1998 Penal Code amendments and the setting up of NCPA were a response to this problem of child abuse and trafficking in children.^{187,191,192,193,196}

One of the major problems in the areas of both sexual exploitation of girls and young women is their victimization through the legal process associated with enforcement of laws on prostitution. Two 19th century colonial statutes, the Vagrants Ordinance (1841) and the Brothels Ordinance (1889) regulate prostitution. Police strictly enforce the Vagrants Ordinance that applies to street prostitution, and also the Brothels Ordinance and round up low income sex workers and girls and women who provide commercial sex in small establishments like lodges and massage parlors. They are detained or remanded often indefinitely, pending court proceedings. They can be convicted to serve a sentence of 14 day imprisonment. The establishments which offer commercial sex with local or foreign sex workers are also sometimes raided by the police under the Brothels Ordinance. However law enforcement is selective and up market establishment is not raided often. This is partly due to uncertainty regarding the legal definition of a Brothel. Some jurisprudence in the Supreme Court gives a broad definition of Brothel, (*Dorothy Silva v Police Vice Squad Pettah* 1977 78 NLR 533) or a narrow definition (*Danny v Sirinimal Silva* 2001 1 SriLR 29). These differences in interpretation have created a perception that it will be difficult to prosecute Brothels owners successfully.

References:^{194,195}

3.5.1.8. Harmful Practices Relevant to Sexual Health

Severe forms of harmful practices such as Female Genital Mutilation do not exist in Sri Lanka unlike in some other countries in the region. Nevertheless some social practices in different communities can be described in this manner.

3.5.1.8.1. Female Circumcision

A recent micro study on HTP claims the existence of practice of symbolic nicking or puncturing with a needle of the vulva in Muslim girls at birth which can be considered under female circumcision. **(197)**. One of the authors Prof Harendra De Silva has also observed evidence of this occasionally in his clinical work.

3.5.1.8.2. Virginity Test in Some Communities

Some communities follow an oppressive custom of requiring the bride to prove her virginity by the demonstration of bleeding when she has intercourse on her wedding night. Failure to “pass” this virginity test leads to tension in the extended family, and is also known subsequently to lead to domestic violence or breakdown of marriage. The practice has its roots in the colonial period where the social value of virginity was emphasized in some communities. It has been highlighted as a gender discriminatory HTP in gender studies¹⁹⁸

Yet it has not been the subject of any public education programmes or a sustained lobby to prohibit it.

3.5.1.8.3. Son Preference

Son or male preference has been recorded in gender studies as a social attitude in many communities. However the recent Demographic Health Survey 2000¹²⁰ indicates that respondents did not reflect son preference except in the estate Tamil community. Social indicators for girls and women indicate that son preference has not led to denial of health or education in any community, or to female infanticide and feticide. Although antenatal sex identification is possible with widespread availability of ultrasound, it is illegal to perform abortions under Sri Lankan law except when the mother’s life is endangered, making it a deterrent for sex selection since any such termination would amount to a “criminal abortion”. Although illegal abortions do take place it is for reasons other than sex selection. (CENWOR study op.cit Note 198)

3.5.1.8.4. Dowry

Dowry is defined in Sri Lanka as a gift given on marriage to a daughter.

In Sri Lanka the giving and receiving of dowry is openly acknowledged even when marriage proposals are posted/advertised in the press. Some incidents of dowry connected domestic violence and divorce which are due to tensions over nonpayment of promised dowry have been recorded, but not on the scale in some other countries in South Asia. (Note.198). Consequently there has not been a consistent or articulate lobby to abolish it. Dowry today may be determined at the time of marriage or before in the form of a portion of woman's inheritance, that is acquired after the death of the parents. In some communities the Dowry may be given to the man in the form of cash, gold or property. When it is given to the woman particularly in the form of gold it becomes 'insurance' for the wife in the event of the husband's death.

3.5.1.8.5. Ragging

Ragging of new students (hazing) is not considered a "harmful traditional practice" as it is not part of any customary practice in any community. However in recent decade it has been practiced in educational institutions across the country, especially at tertiary level. It has its origins in the Colonial period, being associated with the British private schools tradition of 'hazing'

There has been over the years documented evidence of serious physical abuse, sexual violence and mental abuse through ragging, leading to legislation on the subject (see infra State Effort)

3.5.2. International and National Human Rights Standards

3.5.2.1. International Human Rights Standards

The general international human rights standards on reproductive health and services, privacy and discrimination and gender based violence and sexual abuse and trafficking discussed in relation to the other topics, set the standards on promoting sexual health. The Optional Protocol to CRC on Sale of Children, Child Prostitution and Pornography expand on the CRC standards. Sri Lanka ratified this Optional Protocol in 2006. The Palermo Protocol on Trafficking 2000 to the UN Convention against Transnational and Organized Crime 2000 also contains a comprehensive and broad definition of trafficking. The topic of sexual health is not in general addressed specifically in the treaties. However, General Comments of treaty bodies address the issue.

General Comment No 14 of the ICESCR Committee on the Right to the Highest Attainable Standards of Health (2000), interprets Art 12 (2) (a) of the treaty in para 14 as a reference to “sexual and reproductive health services,” but specifically refers to aspects of access to family health care and obstetric services, and access to information on sexual and reproductive health. CRC’s General Comment No 2 (2002) on Role of Independent Human Rights Institutions and General Comment No 5 on General Measures of Implementation and Remedies provide guidelines on implementing and resourcing child rights including adolescent rights in this area. The CRC Committee’s Concluding Observations on country reports have referred to the importance of adolescent’s lack of access to reproductive health services, education and information, and confidentiality. [The Application of Human Rights op.cit p. 95-96].

3.5.2.2. National Human Rights Standards

This is also the position in regard to national human rights standards. Constitutional guarantees relevant to the other areas are relevant to promote law and policy reform in the area of sexual health.

Specific criminal legislation on the subject of ragging in educational institutions, and on sexual and gender based violence namely domestic violence, rape, incest, pornography, sexual harassment, torture and exploitation including trafficking reinforce the international standards on reproductive and sexual health. The Torture Act (1994) seeks to incorporate the standards of the CAT Convention. It criminalizes torture by public officials and provides for prosecution. Constitutional jurisprudence in the Supreme Court interpreting the right to freedom from torture has recognized rape and sexual violence in custody as torture (Note 201). The Penal Code has also been amended to create a strict liability offence of sexual custodial violence. (See 3.5.3 State effort *infra*). Minimum sentences have been introduced for sexual violence. Compensation is also awarded to the victim in Fundamental Rights cases on torture and also when there is a prosecution for sexual violence under the Penal Code. These initiatives are a response to Gender Based Violence against women and children including adolescents of both sexes. They recognize the right to protection of bodily integrity wellbeing and personal security and the

right to reproductive and sexual health. These laws will be discussed specifically and in detail in the section that follows.

As pointed out earlier, laws on parental rights and responsibilities in Sri Lanka recognize the concept of evolving capacity or an age of discretion at which adolescents can make independent decisions and exercise choices in regard to sexual and reproductive health. Sri Lanka law also recognizes the concept of the best interests of the child in jurisprudence, many statutes and a general statutory provision in the ICCPR Act 2007. These concepts harmonize with international standards and provide a basis for recognizing the right to express informed consent, access to information and education confidentiality and privacy in regard to reproductive and sexual health. However when a child is below the given age, the right of privacy and confidentiality comes into conflict with parental rights. This tension has not been resolved in legislation or statutory provisions on child rights, creating a grey area of uncertainty in the standards.

Sri Lanka has also ratified the Optional Protocol to CRC on Sale of Children, Child Prostitution, and Pornography in 2006. It also ratified the SAARC Convention, a regional instrument for South Asia on Trafficking for Prostitution and enacted legislation in 2005 to incorporate these standards. The SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution Act 2005 seeks to incorporate the Convention in national law and provides regulatory controls and enforcement procedures as well as rehabilitation / reintegration measures and support for victims. Discussions on law and policy interventions in this area will review the detailed provisions.

3.5.3. State effort on laws, regulations, policies and implementation

3.5.3.1. Establishment of State Institutions for Protection of children from sexual abuse trafficking and exploitation

In 1998 the government introduced a law to establish the National Child Protection Authority¹⁷³ which resulted in the establishment of the NCPA in June 1999. The mission statement is as follows:

“ In relation to child abuse and exploitation, to create awareness and improve knowledge, undertake training and skills development,

recommend legal reform and monitor law enforcement, undertake special investigations and provide legal support, strengthen the infrastructure to prevent abuse in families, communities, schools and institutions, establish a comprehensive data base including a cyber-watch, undertake relevant research and coordinate the key sectors involved in child abuse and exploitation namely Probation and Child Care Services, Justice and Law Enforcement authorities, Defence, Health, Education and Samurdhi as well as the NGO and INGO networks”.

The National Child Protection Authority (NCPA), Was officially recognized and acknowledged as one of the Best Practices in the World at the Second World Congress against Commercial Sexual Exploitation of Children in Yokohama, Japan: 17-20 December 2001, by the United Nations UNESCAP (United Nations Economic and Social Commission) and published in a book released at the meeting.

The NCPA, a statutory authority created by an Act of Parliament in 1998 and placed under the President in 1999, was transferred to the newly established Ministry of Women’s Empowerment and Child Development in 2006.

3.5.3.2. Education and Human Rights Awareness

As pointed out earlier school education is compulsory in Sri Lanka up to the age of 14(Compulsory Education Regulation of 1997)¹⁸³

Though Sri Lanka has an impressive record in providing access to education and health as a right (see earlier discussion) Sexual Health has not attracted well developed co-coordinated initiatives for many years. Recently however a comprehensive Reproductive Health Module has been developed to cover RH topics. This is to be included in the school curriculum. It has been distributed to all the state sector schools by the Ministry of Education and is to be taught from the age of 11 and to be completed over the following three years. If implemented this would ensure that all school children would have had an opportunity to gain knowledge on Reproductive Health¹⁸⁴

The school curriculum designed by the government which is valid until 2015 identifies reproductive health issues to be taught from grade 6 onwards.

The topics included in the school curriculum are given in table 21.

Table 21: The school curriculum designed by the government till 2015

Skill	Grade 6 (11years)	Grade7 (12 Years)	Grade 8	Grade 9
Good conduct and facing challenges	Successfully Facing Challenges <ul style="list-style-type: none"> • Injuries • Abuse 	Introduction to infections. Basics on ST.I Unsafe sexual relationships, abuse in family and school.	Reproductive health, puberty, anatomy, physiology of the reproductive system, STIs,	Sexuality and responsible sexual behaviour men and women marriage, male responsibility in pregnancy. Sexual abuse, sexual exploitation.

The effectiveness of SRH education needs to be evaluated as above findings clearly indicate adolescent’s lack of knowledge on SRH

In 1993 a National Steering Committee on Adolescent Health was established by the government to coordinate adolescent health activities and develop new initiatives. The committee made valuable recommendations regarding the promotion of adolescent health. As a result of this an excellent manual on RH “Udavu Youvanaya” **(199)** was published jointly by the FHB, HEB and NIE of the Ministry of Health and Ministry of Education and has been distributed to the state run schools

The Draft National Policy of Health of Young Persons section 9 clearly states that young persons have a right to access quality health services without discrimination of any form through youth friendly health services that should conform to National minimum standards especially confidentiality and privacy.

Youth friendly health services which will recognize and respect the reproductive health rights are envisaged in the National Reproductive Health policy. There have also been ad hoc training programmes on human rights, child abuse and sexual health by state and NGOs including women's groups for police, armed forces, teachers, judges and lawyers and for post graduate medical students.

Public awareness programmes on violence against women and children, and child abuse have expanded over the years. These programmes are conducted in the metropolitan areas and at the local level by State agencies like the NCPA and the Women's Bureau, National Committee on Women, and the Ministry of Women's Empowerment and NGOs. Some ad hoc programmes are conducted increasingly in schools as the issue is connected with HIV awareness programmes.

3.5.3.3. Response to Harmful practices

The practice of female circumcision in some Muslim communities may be underestimated because it is not visible, and considered a private matter. Virginity testing has been researched and discussed publicly by women's groups, as a form of GBV. Today it can be considered domestic violence under the Prevention of Domestic Violence Act (2005). Redress may therefore be obtained through the Act if a victim comes forward.

The Government introduced legislation which specifically addresses the phenomenon of ragging, which also covers physical and sexual violence and harassment. (Prohibition of Ragging and Violence in Educational Institutions Act 1998) It has comprehensive provisions which address the problems when these acts are committed in defined tertiary educational institutions and primary and secondary schools within the meaning of the Education Ordinance.

3.5.3.4. Sexual Violence and Responses in Law Reform

In the last few decades the issue of sexual abuse of children and adolescents and GBV against girls and women has attracted attention of women's groups professionals and State. There has been considerable effort to reform laws and procedure on criminal justice replacing 19th colonial laws. Sexual violence is therefore covered in several laws and the policy statement known as the Children's Charter 1992. The major

legislation consists of the Penal Code as amended 1995, 1998 and 2006, the Ragging Act (1998) and the Domestic Violence Act (2005). Sexual violence within the family and outside the family is comprehensively covered by the Criminal law. Offences include rape, incest, sexual assaults amounting to sexual harassment inclusive of those happening in the work place, and a new offence of grave sexual abuse added in 1995 and, defined as serious sexual assaults that do not amount to incest or rape. Except for rape the offences are in general gender neutral and applicable to boys and girls, men and women.

Rape is defined in the traditional Anglo American jurisprudential manner as sexual intercourse with a female without her consent. Incest is sexual acts between persons in a biological relationship or relationship by marriage or adoption which is identified in the Penal Code definition of the offence. Since incest has implications for all members of the family, it was felt that other options such as counseling should be explored. Consequently a decision to prosecute requires the consent of the Attorney General [Penal Code 364 A as amended in 1995].

Any act committed by a person for sexual gratification, by the use of his genitals or any other part of the human body or any instrument or any orifice or part of the body of any other person, is considered as Grave Sexual Abuse under section 365 B and not as rape as in some other legal systems.

Both Rape and Grave Sexual Abuse are punishable by a minimum sentence of up to 20 yrs with or without a fine. However, if the adolescent offender is less than 18 years and the girl is below 16 years i.e. Statutory Rape, the court has discretion to impose a lower sentence. Compensation is also payable for injuries caused from rape. An amendment to the Penal Code (amendment No 16 of 2006) indicates that mental trauma is also covered in payment of compensation.

Forced sexual intercourse with a partner in marriage is not considered as marital rape in Sri Lanka but Section 363(a) Penal Code as amended (1995) states that a man commits rape if he has sexual intercourse with a woman without her consent, if she is judicially

separated from the man or in the case of Muslim marriages if the child bride is under 12 years of age.

The same amendment imposes more severe punishments in the case of gang rape and cases of rape in circumstances like pregnancy, minority (of girls) and mental or physical disability. [Penal Code s 364 (2)]

Rape in custodial situations or official custody, in a remand home or shelter, or institution for women or children, or hospital is considered a grave crime when committed by a person in authority, with enhanced punishments and more serious penalties of imprisonment.

Rape in a custodial situation is a “strict offence” in that the issue of consent is irrelevant, or whether the woman is in legal or illegal custody.

The Supreme Court has in jurisprudence decided that rape and sexual violence committed by law enforcement authorities in custodial situations amounts to an infringement of the Constitutionally guaranteed right to freedom from torture.(Note 201)

Gang Rape, Rape of an Adolescent under 18 years, Rape of a Mentally or Physically disabled person or a pregnant woman is considered a Grave form of Rape with enhanced punishment.

The legal age for sexual intercourse in Sri Lanka is considered as 16 years for both girls and boys. Sex with a girl under 16 years is rape and considered “statutory rape” since the offence is committed irrespective of whether the girl consented. The only exception covers statutory rape of a girl in the Muslim community where the relevant age is 12 years. This is because Muslim personal law does not have a minimum age of marriage, but recognises the consent of a Muslim judge (a Quazi) to the consent of a girl below 12 years. Certain other sexual acts where a girl or a boy under 16 years is considered statutory grave sexual abuse [Penal Code s 363 (e) and s 363 B as amended 1998]

The law reflects a policy, which criminalizes sex with an adolescent less than 16 years considering this child abuse. According to the Penal Code consent for sexual intercourse of a person below 16 is not

recognized as a defence to these offences, on the basis that there is no legal capacity to consent. The law sets age limits in the same way in other areas such as the right to contract, vote, or engage in work outside children's own home.

In recent years, the problem of adolescent sexuality, teenage pregnancy of unmarried mothers encountered by health professionals and NGO's in a context where abortion is illegal, has led to various proposals for changing the law. Some have argued that the age of marriage should be lowered. Others called for a lowering of the age of statutory rape, so that males are not punished for what is seen as consensual sex. In 2007 a proposal to amend the law on these lines met with protest from women's groups who argue that the law of statutory rape and statutory grave sexual abuse are responses to the incidence of sexual abuse and exploitation and set normative human rights standards that must be followed in the community. In a recent case (SC Reference No 03/08 H.C. Anuradhapura NO 333/04) a High Court Judge declared that it was "against her conscience" to impose the minimum sentence for rape by an adult, of a girl under 16 years. She wanted the Supreme Court to express an opinion, (under a reference in terms of the Constitution) regarding whether judicial discretion in sentencing had been removed by the amended Penal Code 1995 which imposed minimum sentences. The Supreme Court, in a controversial interpretation decided that the exercise of judicial discretion was prevented by minimum sentences and its removal was a violation of the judicial power under the Constitution. Currently the trial court judges are following the decision and suspending sentences for sexual offences.

In 2006 S. 360A of the Penal Code on trafficking introduced in the reforms of 1995 was repealed. A new definition of trafficking was introduced with new penalties (See 3.5.3.10)

3.5.3.5. Prosecution Procedures in Cases of Sexual Violence:

An offence of sexual abuse/violence/pornography or trafficking must be first reported to the police or the medical officer in a State hospital who is obliged to report the matter to the hospital police post or local police since it is obligatory to report Penal Code offences. The police will then take a statement from the victim, parents, and any witnesses.

They will investigate the allegation by questioning the accused and/or taking him to custody. It is now not necessary to produce the victim within 24 hours to the Magistrate as previously but within 72 hours allowing more time to investigate. The magistrate will then inquire into the complaint and order the police to send the report to the Attorney General's department to file a case under the Penal Code in the High Court. In the interim period the magistrate could order the custody of the victim to a desirable person or institution. The Judge can order psychological therapy. The case will then be heard in the High Court. Sometimes if the Attorney General is not convinced with the available evidence, a High Court case may not be filed.

Under the National Child Protection Authority (NCPA) Act of 1998¹⁷³ the Chairman of the Authority has the powers to investigate by authorizing NCPA employees to enter into premises if there are reasonable grounds to believe that abuse/exploitation is taking place. The NCPA Act also mentions that the procedure followed should be in the "best interests of the child".

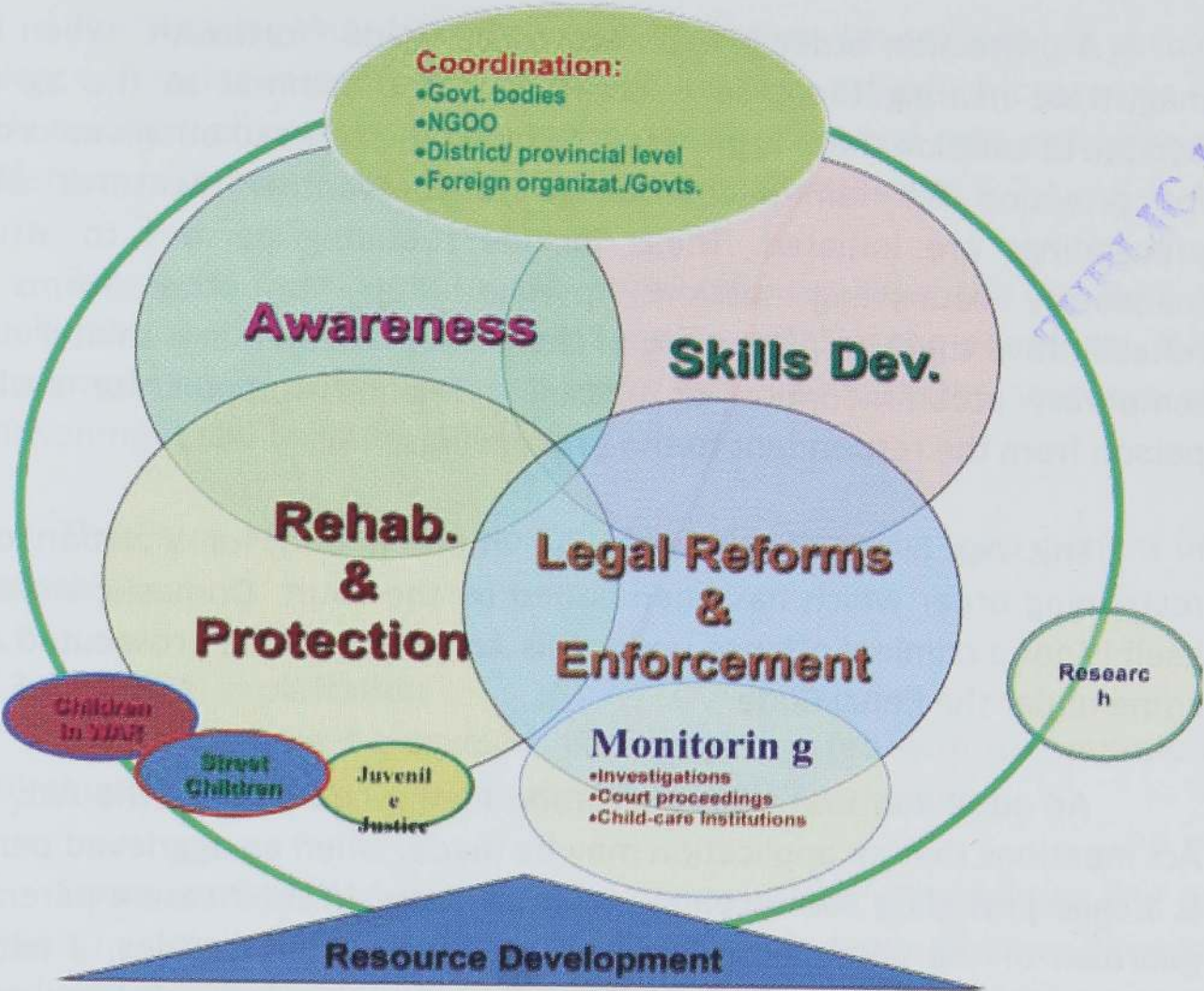
The NCPA as originally established was a National Statutory body with a strong mandate. Apart from creating awareness to the public, it has a mandate to develop skills development programs and activate protective mechanisms to safeguard vulnerable children (including street children, Children in armed conflict and children in institutions) by developing protective mechanisms, as well as legal monitoring and processes including advising government.

In the NCPA, two different Units were set up including a 'Cyber watch' Unit consisting of one computer operator and a Consultant, which monitored the Net for exploitation and trafficking of children. An anti-trafficking Unit sponsored by ILO/IPEC with one surveillance officer, monitored by the Chairman was also setup. These Units were strengthened by the appointment of 2 police officers on secondment. The NCPA had a separate Police Unit with 15 police officers. These three units worked together in combating the problems of child abuse, trafficking and exploitation. Although restricted with inadequate resources, the NCPA conducted some training courses on surveillance with the assistance of the

British Police. The NCPA used simple covert surveillance systems to monitor pedophiles.

Through these strategies the police unit of the NCPA was able to arrest many pedophiles and traffickers both foreign and Sri Lankan. They have also assisted Western countries in their investigations including passing of information to them, including Germany, UK, Belgium, and USA.
187,191,192,193,196

Figure 09: Conceptual framework of the National Child Protection Authority, Sri Lanka



3.5.3.6. Domestic Violence

The Domestic Violence Act (2005) was a result of many years of advocacy by non governmental institutions with state agencies. This was a significant step in providing support to those affected by domestic violence. The Act known as Prevention of Domestic Violence Act No.34 of 2005 is gender neutral and remedies can be obtained by both sexes. It

provides a procedure to obtain a restraining order from the Magistrates' court either directly or through the Police.

Under this Act Domestic Violence is defined as an act which constitutes an offence specified in Schedule 1 which includes, all offences contained in Chapter XVI of the Penal Code, Extortion, and Criminal Intimidation in the Penal Code or an attempt to any of the above **(200)**.

Emotional abuse is covered and described as a pattern of cruel, inhuman, degrading or humiliating conduct of a serious nature directed towards aggrieved persons (affected by domestic violence).

A protection order is expected to be made "forthwith" when the magistrate hearing the case is convinced of the threat to the aggrieved person. In addition there is provision to move the court to obtain an order, for provision for family counseling and preventive measures after proceedings are initiated. These include requiring persons to attend mandatory counseling sessions, psychotherapy or other forms of rehabilitative therapy, placement of the person affected in a shelter or in temporary accommodation or obtaining financial support for such a person from the respondent to the proceedings.

This Act allows penalties to be imposed only for violation of a restraining order which has been issued by the court. Domestic violence itself is not a criminal offence under this Act, and must be prosecuted as a crime under the Penal Code.

An adult can make an application to the court under the Act. The Act mentions that an application may be made, when an aggrieved person is a child (including adolescents) under 18 years. In their case a parent or guardian of the child, a person with whom the child resides, a person authorized in writing by the National Child Protection Authority may apply on behalf of the child. Adolescents must be represented by the parent, guardian or other specified authority, such as the National Child Protection Authority (NCPA) or the State Probation and Child Care Authorities who can initiate the complaint. Although adolescents have the right of direct access to police, NCPA, Probation Department, Police Women and Children's Desks they have no direct access to the court

under the Domestic Violence Act. This is an omission and was not considered when the Act was being drafted. However they are not in general aware of their rights and direct complaints are unlikely. In cases of illegal child labour however children are known to have run away from the site and complained to the police. There is no provision built into the Act to create public awareness of the provisions.

Survivor support including support for children under 18 years is provided for in the manner discussed above in the law. These provisions are gender neutral and are the same for boys and girls.

3.5.3.7. Ragging

The Ragging Act 1998 referred to earlier covers acts of sexual violence. Ragging is defined very broadly as “any act which causes or is likely to cause physical or psychological injury or mental pain or fear to a student or member of the staff of an educational institution.”

Ragging is punishable as a criminal offence under this Act with a penalty of up to 2 years imprisonment and payment of compensation. If it is accompanied by sexual harassment or grievous hurt, the sentence of imprisonment can be up to 10 years.

The Court has the discretion to also order expulsion of a student or dismissal.

3.5.3.8. Sexual exploitation

The criminal laws discussed have been enacted with the intention of eliminating and protecting children from sexual exploitation.

Sexual exploitation is defined in terms of the criminal law and is clarified in detailed provisions in the Penal Code through amendments introduced in 1995, and 2006. The Civil law of damages in Sri Lanka covers injury to persons and also would cover acts of sexual exploitation.

Similarly the law on custody and guardianship imposes responsibilities of care. Sexual exploitation of a child in terms of any acts covered by the criminal or civil law will provide a basis for interference

with custody and guardianship. This law is based on the concept of both elimination and protection from sexual exploitation.

The Tsunami Special Provisions Act (2005) has provisions which can also be considered laws aimed at eliminating sexual exploitation and preventing it.

Third parties can initiate proceeding under Tsunami Act, or in proceedings in Court to interfere with custody / guardianship on the basis of sexual exploitation of a child/ adolescent in their care. They may complain to NCPA or Probation authorities.

The general statement of the right to protection from abuse in the ICCPR Act 2007 also recognizes the importance of eliminating and protecting children from sexual exploitation. It can help promote law reform, strengthen law enforcement, and the prosecution of offenders. There does not appear to be awareness of the important provisions of this Act on the subject of children's rights.

This Act [s.5 (1) (c)] is a general enactment on rights and recognizes specific child rights including the child's right to be "protected from maltreatment neglect abuse or degradation". S.5 (d) recognizes the right to also obtain legal assistance in criminal proceedings affecting the child "if substantial injustice would otherwise result"

This seems to strengthen the enforcement of the criminal law, since an action can be brought in the High Court in the case of violation or threat of infringement by executive or administrative action. This provision can therefore be used to make the State law enforcement officers and prosecutors accountable for taking action and prevent official inaction in regard to prosecutions, etc.

3.5.3.9. Pornography

Child pornography is criminalized in the Penal Code as amended under a chapter on offences to decency and morals by:

(1) A specific offence called obscene publications and exhibition relating to children.

- (a) Any person who hires, employs, assists, uses or persuades or coerces a child to participate in an indecent or obscene exhibition or show or pose or model for this in photographs or films or sells or distributes such material commits an offence.
- (b) A parent or guardian or custodian who causes or allows a child to be so used also commits an offence.
- (c) Any one who takes or assists in taking any indecent photograph or distributes any photograph or publication with such a photograph commits an offence.
- (d) Possession of or possession for distribution of such material is an offence.
- (e) Publication of such material or advertising them is an offence.
- (f) Failure by the developer or photographer or films to inform the police that he has in his possession such material, given to him for developing is an offence.

(2) Pornography can also be prosecuted under the offence of sexual exploitation that falls within offences to the body. There is duplication in this regard.

3.5.3.10. Trafficking

Trafficking is covered extensively in the Criminal law, in the general statement on right to protection from abuse in ICCPR Act 2007 and in the recently enacted SAARC Convention on Trafficking in Women and Children Act 2005 incorporating some aspects of the SAARC Convention that Sri Lanka has ratified.

The Penal Code contains the offence of procurement for prostitution and soliciting in children for sexual abuse. (See 5.4.12 and 5.4.13) s365 (A) on homosexuality (5.4.13) also covers the offence of procuring for this purpose. These laws could cover cases of trafficking. In addition there is a specific offence of Trafficking. The existence of these different offences relating to the same subject of trafficking has created confusion and problems in investigation and law enforcement. (K.A.P Survey on Trafficking unpublished study CENWOR 2008)

S.360(C) Penal Code as amended 2006 which repealed s.360 (C) introduced in 1995 created a new offence of Trafficking. The new

definition of trafficking has been influenced by the Palermo Protocol (2000) on trafficking, to the UN Convention against Transnational and Organised Crime (2000).

(1) Trafficking is defined in terms of the international standards on trafficking as buying, selling or bartering any person or instigating or inducing another person to do so for money or other considerations. It also covers promotion, facilitation or inducing such conduct, using **some** of the language of the Palermo Protocol. The definition of trafficking is not as wide as in the Palermo Protocol. (S. 360 C (1)(a)).

(2) Trafficking also covers transporting recruiting, transferring, harbouring or receiving any persons by use of threat, force, fraud, deception or inducement, or by exploiting vulnerability for the purpose of securing forced and compulsory labour, slavery or servitude. The definition covers similar conduct for the purpose of;

- (i) Organ removal
- (ii) Prostitution or other form of sexual exploitation
- (iii) or to commit an offence under the law. (360 C (1) (b))

(3) Trafficking is also defined separately as trafficking in children. (360(C)(1)c). International standards on trafficking indicate that the consent of the person trafficked is not relevant. However the consent issue is not referred to in the definition of Trafficking in (1) and (2) above. Consent is referred to as not relevant only in the offence of trafficking in children. The definition of child trafficking however does not use the phrase threat force or fraud etc. in (2) above, though trafficking in children is described in language similar to (2) above. These differences in definitions make for confusion in the law on trafficking.

Penalties

2 – 20 years imprisonment and or fine

3 – 20 years imprisonment and or fine

in case of a child (under 18 years).

No special additional factors are relevant to penalties.

Special Vulnerabilities

These are addressed in the general definition and in the slightly increased penalty in the case of trafficking in children under 18 years.

Procedures

No special procedures are given in regard to trafficking. Enforcement is virtually nonexistent, according to a recent KAP survey undertaken by an NGO, CENWOR. The duplication of criminal offences in relation to Trafficking and lack of awareness of the complex legal provisions among both prosecutors and law enforcement agencies is a major problem, in addressing internal trafficking. External trafficking is connected with failure to regulate effectively migration for overseas work. The Foreign Employment Bureau has many programmes and a system of licensing and welfare and support services but they have not been effective to prevent trafficking in this area. A recently established multi state agency Task Force of the Ministry of Justice appears to have had some impact in strengthening law enforcement.

SAARC Convention on Preventing and Combatting Trafficking in Women and Children in Prostitution Act 2005 of Sri Lanka

This Act covers specifically the area referred to and is therefore different to the other law on procuration, trafficking and soliciting.

It seeks to incorporate some aspects, but not all the provisions of the regional instrument, the SAARC Convention that Sri Lanka has ratified. It comes into operation as a law only when the Minister (not clear which Minister) publishes an order in the official government gazette certifying the date on which the Convention enters into force in Sri Lanka. It appears that this has not been done.

The CENWOR KAP Survey indicated that the officials and law enforcement agencies responsible for interventions under the existing law are not aware of the SAARC Convention Act or its implications. Key Provisions of the SAARC Convention Act 2005

Offences created under the Act cover only keeping, maintaining or managing knowing or taking part in financing, knowingly letting or renting

a **building** or other place **for trafficking in women and children** for prostitution or connected matters.

Trafficking is defined as moving, selling buying women and children for internal or cross border trafficking for money or other consideration with or without consent of the woman or child. But this does not conform with another definition of trafficked persons, creating confusion in relevance of consent. Prostitution is defined as “sexual exploitation or abuse for commercial purposes.”

The penalty is a prison sentence of 3 to 15 years. Compensation may be paid to the victim. Persons subjected to trafficking are specifically defined as women and children victimized or forced into prostitution and trafficking by deception, threat, coercion, kidnapping, sale, fraudulent marriage or other unlawful means. Consequently consent of an adult or an adolescent above the age of discretion will limit the Act.

Procedures

The Colombo High Court has jurisdiction to hear, try and punish the offences under the Act.

This Court has been conferred with jurisdiction even if the offence has been committed outside Sri Lanka, provided the victim is a Sri Lankan or the offence is committed by a Sri Lankan citizen or a stateless person with habitual residence in Sri Lanka, or the alleged offender is in Sri Lanka.

3.5.3.11. Sexual Torture

There has been State response to sexual violence against women. The Torture Act 1994 referred to earlier seeks to incorporate CAT and as pointed out jurisprudence of Supreme Court has recognized rape and sexual violence as torture.²⁰¹

As stated earlier the Penal Code was amended in 1998 to make rape in custody a strict offence where the crime is committed irrespective of proof of consent.

Figure 10: Implementing the law: Intervention by State Authorities
Individuals and Adolescents in cases of sexual violence

- (i) State authorities can intervene. E.g. Women and Children Police Desks, Probation and Child Care and NCPA and bring court action or relevant administrative proceedings to ensure that other relevant State agencies respond.
- (ii) Adolescents have the right of direct access to police, NCPA, Probation Department, Police Women and Children's Desks. However they are not in general aware of their rights and direct complaints are unlikely. (In cases of illegal child labour however children are known to have run away from the site and complained to the police).
- (iii) As pointed out earlier in cases of placement in care under juvenile justice law, an adolescent's right to be heard is recognized and decisions must be made in their best interests. However there is no procedure to ensure this.
- (iv) Criminal prosecutions, DV restraining orders, payment of compensation in criminal prosecutions and civil action for damages, denial of parental or guardianship and custodial rights by courts, and placement in care under juvenile justice law are the contemplated interventions. However, law enforcement monitoring and follow up is usually inadequate.
- v) Judicial Medical Officers offer emergency services to victims of violence including emergency contraception where relevant.

3.5.4. Barriers in laws, regulations and policies and Implementation
SRH Education

1. (a) Although policies support SRH education in principle, SRH education programmes are not being effectively implemented. Difficulties are complex and multiple. It is not culturally acceptable in most communities in Sri Lanka to discuss sexual relation in the family context or in schools. The change makers for SRH education, the teachers themselves are usually uncomfortable discussing sexuality issues among themselves or their families. The training they receive is inadequate for the purpose of teaching the curriculum and when given it is knowledge focused rather than helping to promote attitudinal change

The erroneously interpreted cultural values propagated by policy makers contribute to teachers taking a defensive stand and avoiding discussing these issues. They perceive open discussion as creating an environment detrimental to the child. This was evident when the educational booklet “Udavu Yauvanaya” was distributed to the schools. The concern about contraception, which was only mentioned briefly, prevented the booklet being used in schools.

(b) There is a lack of knowledge of legal age of marriage, legal age of consent for sex and the issue of statutory rape, by parents, guardians, teachers, professionals and adolescents. There is a gap between the realities of adolescent sexuality and legal and social policies on these aspects leading to these relationships being considered either legal, (when they are not) or illegal (when they are legal).

2. Harmful Traditional Practices

(a) There have been no awareness raising interventions to prevent practices such as female circumcision. Practices such as virginity tests and female circumcision would constitute criminal conduct in the Penal Code under offences such as hurt and assault or sexual harassment, though not covered by specific provisions. These issues are hidden from public view and continue without state intervention.

(b) Despite continuous advocacy to change some aspects of personal law, which reflect preferential treatment of the son, such as laws related to inheritance, they have not yet been reviewed and amended

(c) Dowry as a HTP (Harmful traditional Practices) has been raised in gender studies and is considered discriminatory since it is increasingly given as a marriage gift to the bridegroom. Yet there have been no public awareness campaigns to undermine even this form of the practice or a lobby for legal reform prohibiting gifts of dowry to a woman or a man.

3. Law Enforcement and Administration of Criminal Justice

Poor investigation, inability to sustain prosecutions and victim intimidation are flaws that prevent effective law enforcement. In response a Victim's Protection Statute is being prepared for presentation to Parliament, to address the latter problem. Although High profile cases are prosecuted, sometimes successfully, there is public disenchantment with the administration of criminal justice and a culture of impunity has developed over the years. The Domestic Violence Act provisions require representation of children, and adolescents are not considered as a separate category. Adolescents may lack access to courts and there is no procedure to facilitate this. There is no identified procedure for respecting wishes of adolescents or to ensure their participation rights in legal proceedings even when the law provides. There have been press reports of abuse of victims in shelters and transport of victims in prison vehicles sometimes with the defendant.

Coordination between the key agencies and sectors involved in child abuse and exploitation (4.5.3.1) is inadequate.

Because the age of marriage is 18 years, when adolescent sexuality takes place ,families tend to facilitate early marriage of girls below the legal age of 18 years. This leads to corruption and falsification of birth certificates. There has been recent, very strong anecdotal evidence of pressure for early marriage of girls in areas affected by the conflict

4. In regard to prosecutions:

(a) The social stigma relating to reporting sexual violence and the mistrust in the effectiveness of the legal processes due to prolonged delays, and complex medico legal procedures discourages victims seeking legal remedies. This is especially applicable to adolescents.

(b) Lack of opportunities for relocation discourages victims from coming forward to complain or continue with legal proceedings. They may abandon judicial processes by refusing to come for judicial hearings.

Victims who particularly come from low income families are unable to access the compensation that they are entitled to and therefore may accept money from the defence to drop the proceedings.

(c) Lack of awareness of victims of the need to seek medico legal assistance immediately, often prevents successful investigation and prosecution. There is a public perception of ineffective investigations in cases of sexual violence.

(d) Although the non summary inquiry procedure in the lower courts has been abolished, and cases can be prosecuted directly by indicting an accused, a considerable delay may occur in bringing the accused to trial.

5. Abuse of power and corruption in the police as reported negatively impacts on achieving justice to adolescent victims of sexual violence
6. Trafficking laws are complex and there are conflicting provisions, making implementation very difficult. The 19th century Colonial laws on vagrancy and brothels are archaic and contribute to victimisation of women and adolescent girls. Definitions of trafficking are not in line with international standards.
7. Some argue that minimum sentences introduced under the 1995 Penal Code Amendment are “Draconian”, in nature. Those who support the reforms argue that minimum sentences would be a deterrent to sexual violence and ensure consistency in sentencing policy of the courts. The recent controversial judgement in Supreme Court deciding that the Penal Code amendment on minimal sentences is contrary to the judicial power regarding sentencing (S C Determination 2008) is followed and trial courts are pronouncing orders of suspended sentences (where the sentence of the accused is not served) .This has led to a situation where a trial courts are orders exercising discretion in sentencing rather than imposing the minimum sentence given in the Penal Code.
8. (a) There is anecdotal evidence from service providers who are working with children that some trial court judges and lawyers do

not seem to have adequate knowledge of the Domestic Violence Act or its procedures.

(b) The Act does not allow an adolescent between 16 and 18 who is above the discretion for sexual consent, to access courts for redress directly.

(c) There are very poor facilities for Counselling and rehabilitation services making implementation of the legal provision difficult

9. Enforcement of child abuse laws present many challenges due to inadequate resources such as shelters for victims including adolescents.

10. (a) Lack of resources for preventive education programmes, the priorities given to reactive interventions and poor understanding by authorities of the value of investing on prevention.

(b) Cost of awareness raising programmes are prohibitive. There are no obligatory regulations for free or concessionary air time and social programmes are charged at commercial rates

(c) Lack of professionalism (partly due to non availability of appropriate personnel and resources) in development and implementation of preventive programmes has negative impact on adolescent's inclination to access these programmes.

12. (a) Although adolescents are provided free therapeutic State services like any other group, it is very unlikely that they will be as open as an adult to seek advice, guidance or care from a state institution. The service providers need to be sensitized on their special need for privacy and confidentiality. The lack of this special focus in the service provision mechanism is a barrier.

Although there are a few service programmes in state hospitals through NGOs, there are no specifically identified and dedicated service units for GBV victims including adolescents. Similarly adolescents facing violence in juvenile justice and child abuse have limited resources for therapeutic interventions.

(b) Lack of adequate staff to counsel victims is a barrier. At present no cadre has been identified in the MoH, although few counsellors

are attached to the courts who would help to provide the mandatory counselling.

13. Homosexuality continues to be illegal and the law has not been reviewed, though the criminal provision on adult homosexuality has not been enforced. Since homosexuality is illegal this can have an impact with regard to targeting specific interventions in regard to adolescent homosexuality issues.

3.5.5. Recommendations

1. Information on the legal age of marriage, age of discretion sexual consent and responsibility, the best interests of the child and evolving capacity should be integrated into State RH Education package and life skills module and curricula in the state education system. Health professionals should be trained on the relevance and importance of these concepts. Priority should be given to educational/ awareness raising programmes on sexual health and responsible sexual behavior and sexual relationships.

The ICCPR Act (2007) should be amended to specifically refer to age of discretion at 16 years for both boys and girls and right to informed consent and privacy depending on evolving capacity (see early child bearing recommendations). Provisions of the Act on the subject of child rights should receive publicity.

Responsible authority: Ministry of Justice, Ministry of Health.

2.
 - (a) There should be public education programmes using media on negative dimensions of virginity testing and female circumcision, and that these practices are illegal.
 - (b) There should be a law reform initiative to eliminate gender based discrimination in the personal laws including the recognition of a minimum age of marriage for Muslim girls in the best interest of the children ,so as to harmonize personal laws with Constitutional and human rights standards, linking with groups from within communities who are promoting reforms.
 - (c) Legal reforms regarding preferential treatment of sons regarding inheritance is recommended, where such principles are found in State land distribution laws and personal laws.

Responsible authority: Ministry of Justice, Ministry of Education and Ministry of Women's Empowerment.

3. (a) The state needs to ensure an accountable system for administration of criminal justice considering the poor investigatory procedure, inability to sustain prosecutions and victim intimidation which would improve the credibility of the legal system in the eyes of the public.

(b) Victim protection legislation should be introduced.

Responsible authority: Ministry of Justice, Attorney General's Department.

4. There should be sustained training programmes on adolescent's rights to SRH from human rights perspectives for the health professionals and law enforcement agencies

Responsible authority: Ministry of Justice, Ministry of Health and Ministry of Defence.

5. Strengthen procedures for birth and marriage registration to address the problem of corruption and falsification of registration entries through relevant State authorities, and obtain the support of Trade Unions to ensure maintenance of professional standards.

Responsible authority: Ministry of Justice, Registrar General's Department, Bribery Commission, Trade Unions of Registrars.

6. (a) Ensure prioritization of procedure in the medico legal process in handling sexual violence offences

(b) Provision of adequate compensation, relocation programmes and active intervention by the state in cases where possible bribery or intimidation of witnesses has taken place

Responsible authority: Ministry of Justice, Ministry of Health

7. (a) Making the public and adolescents aware of the need of early reporting and interventions for successful prosecution

(b) Combine training programmes for legal and medical professionals in the critical importance of forensic procedures investigation techniques in order to strengthen capacity for

successful prosecution in case of sexual violence. Such programmes should be integrated to the curricula of medical and law schools.

Responsible authority: Ministry of Justice, Ministry of Health, Universities, Medical and Law Faculties and Departments, University Grants Commission.

8. (a) Prosecution of medico legal personnel and Police for abuse of power and corruption.
(b) Sensitization of Police, health professionals and judiciary on ASRH and the importance of ensuring justice for adolescent victims of sexual violence

Responsible authority: Ministry of Justice, Ministry of Health, Inspector General of Police

9. Ensuring quick progress in prosecution process to minimize the harm to the victim of sexual crimes, especially at the stage of preparation of papers for prosecutions.

Responsible authority: Ministry of Justice, Attorney General's Department, Inspector General of Police

10. A comprehensive holistic review of current trafficking and prostitution laws should be undertaken to eliminate duplication and complexity in the provision and conform with Sri Lanka's international treaty commitments. The Vagrants and Brothels Ordinance should be repealed. International standards should be considered in the process of reviewing the law. Contradictions between the international standards and SAARC Convention should be addressed.

Responsible authority: Ministry of Justice,

11. Multidisciplinary dialogues to be initiated to address the negative effects of discretionary sentencing without consistency.

Responsible authority: Ministry of Justice, Attorney General's Department, Judges Training Institute, National Legal Education Institutions (State and Private)

12. There should be an amendment to the Domestic Violence Act to clarify that harmful traditional practices can constitute domestic violence, and that giving and receiving cash, movables or property

as part of a marriage transaction except as a free will gift to the bride herself can amount to domestic violence. Amendments should also provide for adolescents to initiate complaints.

(b) Training for judicial officers through the Judges Training Institute on the legal changes in the area of child abuse children's rights, the ICCPR Act 2007 and Domestic Violence Act 2007 to create awareness and sensitivity regarding concepts such as best interests of the child, evolving capacity and informed consent and the critical importance of avoiding delays in legal procedures.

Amendments can be introduced to the ICCPR Act which already refers to child rights and to the right of the child under 18 years to legal aid in some circumstances. These amendments must clarify procedures, so that adolescents can exercise their right to be heard in legal proceedings.

Responsible authority: Ministry of Justice, Judges Training Institute.

13. Resources for effective law enforcement including shelter for adolescent victims must be provided by the State

Responsible authority: Ministry of Justice,

14. Maximum use should be made of print and electronic media of the state and private sector to focus on promoting adolescent sexual health and responsible sexual behavior and prevention of sexual violence. Possibilities of sponsorship of the corporate sector should be explored.

Responsible authority: Ministry of Justice, Ministry of Media, Ministry of Health

15. (a) There should be a focus on adolescents and health service provision, in the State health sector and in programmes of NGO's offering services. There needs to have be adolescent health clinics and service provision guidelines.

(b) There should be a programme on training counselors so as to strengthen their capacity to offer psycho social support to adolescents and victims of sexual violence.

(c) Strengthen action for legal aid and counseling through the State and NGO sector

Responsible authority: Ministry of Justice, Ministry of Health, Relevant NGOs

16. Address the problem of providing access to relief and remedies for victims of sexual and gender based violence in former conflict affected areas by resourcing and developing integrated responses from the State and other stake holders such as the Police Women and Children's Desks, the Medical Professional Organizations ,the Human Rights Commission, and NCPA .

Responsible authority: Ministry of Women's Empowerment, Human Rights Commission, Attorney General's Department, MoH

17. Review the current law and policy in regard to homosexuality and ensure that counseling services with regard to sexual orientation are made available to adolescents who need such services.

Responsible authority: Ministry of Justice, Ministry of Media, Ministry of Health, Human Rights Commission

18. Strengthen the capacity of civil society groups to use the Optional Protocol procedures under CEDAW and the ICCPR in relation to issue of adolescent reproductive health.

Responsible authority: NCW, Human Rights Commission

19. Promote early introduction of Women's Rights Acts proposed by the Ministry of Women's Empowerment and Child Development.

Responsible authority: Ministry of Justice, Ministry of Women's Empowerment, Human Rights Commission

20. Promote the development of codes of practice on child abuse, gender based and domestic violence by professional medical bodies for their membership.

Responsible authority: Ministry of Justice, Ministry of Women's Empowerment, Human Rights Commission, Professional Medical Associations, Sri Lanka Medical Associations, Sri Lanka Medical Council

21. Review the institutional arrangements on child care services including child protection and the role of the NCPA.

Responsible authority: Ministry of Attorney General's Department
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