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# STATE OF HUMAN RIGHTS

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# THE RIGHT TO HEALTH IN SRI LANKA : CHALLENGES, CONTESTATIONS AND CONTRADICTIONS

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## 1. Introduction

The Universal Declaration of Human Rights (UDHR), adopted by the United Nations (UN) General Assembly in 1948, enshrines the right to health, defined broadly to encompass standards of living sufficient for health and wellbeing, including food, shelter, medical care, social services, and the right to security.[1] Since then, the right to health has made its way into numerous UN treaties, including, the International Covenant on Economic, Social and Cultural Rights (ICESCR; 1966), International Convention on the Elimination of All Forms of Racial Discrimination (ICERD; 1965), Convention on the Elimination of All Forms of Discriminationagainst Women (CEDAW; 1979), Convention on

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1. UN (1948). Universal Declaration of Human Rights. https://www.un.org/en/about-us/universal-declaration-of-human-rights

the Rights of the Child (CRC; 1989) and the Convention on the Rights of Persons with Disabilities (CRPD; 2006).[2] ICESCR deals with the right to health most comprehensively where Article 12 recognizes the right to enjoy the "highest attainable standard of physical and mental health."[3]

In Sri Lanka, the constitution does not explicitly guarantee the right to health. However, the fundamental rights enshrined in the constitution address the right to equality, including protection from discrimination based on "race, religion, language, caste, sex, political opinion, place of birth" or "such grounds,"[4] which may be extended to the provision of health and other services. With respect to the country's international commitments, Sri Lanka has acceded or ratified a series of legally binding UN treaties including the ICESCR (1980), CEDAW (1981), ICERD (1982), CRC (1991) and CRPD (2016), which all reference the right to health.[5]

This chapter offers an overview of how the Government of Sri Lanka respected, protected and fulfilled its commitments to the right to health in the time period 2018 to 2020. The period is remembered for several incidents that had wide-ranging health consequences, including the organised anti-Muslim riots that occurred both before and after the Easter bombings of 2019, sending shockwaves across the country and a backlash against Muslim communities, and also the advent of the COVID-19 pandemic in 2020 and its long lasting social, political and

2. Office of the High Commissioner on Human Rights (OHCHR), 1996-2022
3. UN (1967).
4. *The Constitution of the Democratic Social Republic of Sri Lanka* Revised edition – 2021, Parliament Secretariat, 2021, https://www.parliament.lk/files/pdf/constitution.pdf
5. OHCHR, n.d.

economic impact. In addition, the health sector had to grapple with an ever-increasing burden of Non-Communicable Diseases (NCDs), intensified by demographic changes, in particular, a rapidly aging population. The chapter begins by introducing the right to health as explicated by the UN Committee on Economic, Social and Cultural Rights (CESCR), and then examines the extent to which Sri Lanka respected, protected and fulfilled the right to health between 2018 and 2020, focusing first on the availability, accessibility, acceptability and quality (3AQ) of health services, and then on a number of specific groups and issues that were, and still are, troubling in the Sri Lankan context. The chapter concludes by pointing to some areas overlooked by rights-based approaches that may merit attention.

## 2. The Right to Health

In 2000, the UN's CESCR interpreted the right to health in General Comment 14 (GC 14) as being dependent on a series of other economic, social, civil and political rights, and as embodying both freedoms and entitlements; here, freedoms included the "right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation,"[6] while entitlements included the "right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable

6. General comment no. 14 (2000), "The Right to the Highest Attainable Standard of Health" (Article 12 of the International Covenant on Economic, Social and Cultural Rights). United Nations Digital Library. https://digitallibrary.un.org/record/425041?ln=en CESCR, 2000, (emphasis added).

level of health"[7] (emphasis added). This health system, according to CESCR, should ensure access to health services as well as the underlying determinants of health, including "access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."[8]

With respect to health services, GC 14 addresses four areas, namely availability, accessibility, acceptability and quality (3AQ). Healthcare and other services/utilities like water and sanitation must be available. They must be accessible (inclusive of physical, economic and information accessibility); here, economic accessibility should be ensured irrespective of whether the services are publicly or privately provided. Services must be delivered in a form that is acceptable to the community, respecting its needs, values, and the broader sociocultural context. Finally, they must be of sufficient technical quality. In particular, the CESC Remphasized equity and non-discrimination, and asked that States ensure the participation of citizens in decisions on health at community, national and even at global levels.[9]

As per the UN's interpretation then, the right to health extends far beyond the health sector, and is inextricably linked with other freedoms and entitlements that impact physical, mental and social wellbeing.

7. General comment no. 14 (2000), "The Right to the Highest Attainable Standard of Health" (Article 12 of the International Covenant on Economic, Social and Cultural Rights). United Nations Digital Library. https://digitallibrary.un.org/record/425041?ln=en CESCR, 2000, (emphasis added).
8. Ibid
9. Ibid

## 3. Sri Lanka and 3AQ (availability, accessibility, acceptability and quality)

### *3.1 Availability of health services*

GC 14 specifies that "functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party," including the determinants of health, such as "safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs."[10]

The healthcare system in Sri Lanka is made up of a non-fee levying public healthcare system and a fee-for-service private health sector. Between 2018 and 2020, government spending on health was less than 2% of the GDP with about 9% of the budget going to the public health sector.[11] The public healthcare system comprises state-owned and -administered healthcare facilities that are free of charge at the point of use, estimated to purvey about 90% of inpatient admissions and the bulk of preventive care.[12] Despite impressive levels of coverage, especially for mothers and children extending even to rural and remote areas, acute resource constraints limit the availability of services for other health problems. A large proportion of outpatient visits for NCDs take place in the fee-levying private sector, accounting for significant levels of out-of-pocket expenses on consultations,

10. Ibid
11. World Bank, 2022.
12. Owen Smith, "Sri Lanka: Achieving Pro-poor Universal Health Coverage without Health Financing Reforms," 2018, https://openknowledge.worldbank.org/handle/10986/29175

tests, and medicines.[13] Moreover, budgetary allocations for elderly care, long-term care, rehabilitative care, and palliative care are inadequate to sustain service delivery in the public sector, translating to inequities in access, especially for resource intensive treatments and procedures.[14]

Regional disparities in healthcare workers are widespread, disadvantaging rural and war-torn districts. According to data published by the Ministry of Health, in 2017, 620 specialists, 4,745 medical officers and 8,562 nurses served in the Colombo District, compared with 147 specialists, 1,208 medical officers and 1,234 nurses in all five districts of the Northern Province. Such disparities are especially visible at the primary care level in rural and remote areas.[15] For instance, in 2017, Kilinochchi district had 3 medical officers in the preventive sector versus 16 in Jaffna and 61 in Colombo.[16] Similarly, Mullaitivu district had 42 public health midwives as compared to 138 in Jaffna and 418 in Colombo district.[17] With respect to physical resources, if we consider the acute management of NCDs, in 2017, there were 193 cardiology beds in the Colombo district, versus 24 in Jaffna district, the latter serving all five districts of the Northern Province.[18] In 2020, 344 intensive care unit (ICU) beds were located in Colombo versus 30 in the Northern Province.[19] Admittedly, the post-war Northern Province is sparsely populated, accounting

13. Legido-Quigley et al., "Patients' Experiences on Accessing Health Care Services for Management of Hypertension in Rural Bangladesh, Pakistan and Sri Lanka: *A Qualitative Study,*" *PLoS One,* 14 no 1 (2019) .(1), e0211100, 2019.
14. WHO, 2021.
15. Ministry of Health, 2017.
16. Ministry of Health, 2017.
17. Ministry of Health, 2017.
18. Ministry of Health, 2017.
19. WHO, 2021.

for about 5% of the country's population compared with 11.3% in Colombo District. However, the Northern Province accounts for a much greater land mass (13.2%) compared to that of Colombo (1.1%), reflecting the disparities in service availability between Colombo and peripheral districts. Even within districts, tertiary care services tend to be concentrated in urban centres, disadvantaging rural communities.[20]

The private sector delivers over half the volume of outpatient services.[21] Most private sector doctors, including general practitioners and specialists, are full-time employees of the Ministry of Health.[22] Thus, the availability of private outpatient care tends to mirror the availability of public healthcare services. Private general practitioners, most of whom are dual practitioners, run independently managed outpatient facilities close to where they work, in both urban and rural areas, while specialists consult in the private sector in urban areas where public hospitals tend to be concentrated. However, as private hospitals tend to be concentrated in urban areas, especially in Colombo and its suburbs, there are significant disparities in the availability of private inpatient care. Such urban—rural disparities in the availability of private hospital services translate to far wider inequities in access as they are financed chiefly through out-of-pocket payments.[23]

20. Ministry of Health, 2017.
21. WHO, 2021.
22. Ramya Kumar, "The Privatization Imperative: Women Negotiating Healthcare in Kandy, Sri Lanka," PhD [dissertation],(University of Toronto, 2018),https://tspace.library.utoronto.ca/bitstream/1807/82972/3/Kumar_Ramya_201803_PhD_thesis.pdf
23. Ramya Kumar, "Public–Private Partnerships for Universal Health Coverage? The Future of "Free Healthin Sri Lanka." *Globalization and Health,* 2019, 15(1), 1-10. https://doi.org/10.1186/s12992-019-0522-6

### *3.2 Accessibility of health services*

GC 14 defines accessibility in terms of physical, economic and information accessibility, and underscores accessibility without discrimination.[24] Physical accessibility of services is linked with their availability, discussed in 2.1, as well as disability accessibility.

In 2018, 52% of health spending came from private sources: 81% of this was paid out-of-pocket by households.[25] As private healthcare services are delivered primarily on a fee-for-service basis, the private sector remains largely inaccessible to economically disadvantaged communities. Thus, any shortfalls in public healthcare ultimately translate to compromised financial accessibility. Even the poorest are compelled to spend on laboratory tests and medicines in the private sector, with levels of out-of-pocket expenses in the private sector rising steadily over time.[26]

Catastrophic health expenditures—defined as healthcare spending that exceeds a household's capacity to pay—are relatively low because the public system covers the bulk of inpatient care.[27] Even so, some resource-intensive treatment modalities like coronary artery bypass grafting ("bypass"), dialysis or kidney transplant, and specific cancer therapies, are in short supply at public hospitals, requiring people to wait in line for months if

24. CESCR, 2000.
25. "Sri Lanka Health Accounts: National Health Expenditure 1990-2019," Institute for Health Policy, 2021.https://www.ihp.lk/publications/docs/HES2106.pdf
26. Ajantha.Sisira Kumara &RamanieSamaratunge, "Patterns and Determinants of Out-Of-Pocket Health Care Expenditure in Sri Lanka: Evidence from Household Surveys," *Health Policy and Planning*, 31, no8 (2016): 970-983, https://doi.org/10.1093/heapol/czw021
27. Owen Smith, "Sri Lanka: Achieving Pro-Poor Universal Health Coverage Without Health Financing Reforms," 2018https://openknowledge.worldbank.org/handle/10986/29175

not years,[28] incurring health expenditures on transport and time off work, not to mention the associated adverse health outcomes. Meanwhile, households with means circumvent such service delays by accessing care in the private sector.[29] Apart from access inequalities based on ability to pay, pervasive deficits in disability accessibility makes the healthcare system, regardless of sector, unwelcoming toward persons with disabilities(more details in Section 8).[30]

Information (in) accessibility is also a concern; healthcare users, in both public and private sectors, frequently receive inadequate information from healthcare providers. The 2016 Demographic and Health Survey (DHS) reported that about half the female contraceptive users surveyed did not receive information on the side effects of contraceptives or the methods available.[31] This lack of information has also been documented in obstetrics,[32] and cancer care.[33] Furthermore, young people have restricted access to sexual and reproductive health information, with comprehensive sexuality education yet to be introduced to the health education curriculum, even at the secondary school level.[34]

28. Ibid.
29. Kumar et al., 2018
30. LakshilaWanigasinghe, "Leave No One Behind: Building a Disability-Inclusive COVID-19 Recovery Plan for Sri Lanka", Talking Economics, IPS Blog, https://www.ips.lk/talkingeconomics, 2021, more details in Section 8.
31. Demographic and Health Survey ,2016, Department of Census and Statistics (2017) http://www.statistics.gov.lk/Health/StaticalInformation
32. Kanya D' Almeida, 2020-2022), *The Darkest Light.* https://thedarkestlight.buzzsprout.com/
33. Chrishanthi. I. Rajasooriyar et al., (2021). "Exploring The Psychosocial Morbidity of Women Undergoing Chemotherapy for Breast Cancer in A Post-War Setting: Experiences of Northern Sri Lankan Women," *Supportive Care in Cancer,* 29(12), (2021): 7403-7409. https://doi.org/10.1007/s00520-021-06296-5; N. Soysa, "Am I Ready to Die?", 2021, https://www.youtube.com/watch?v=cwomFLADUCk
34. Nisali De Silva, " 'Hathe Ape Potha' Was Product of Much Effort and Research, Says Author," *Economy Next,* 2020, https://economynext.com/hathe-ape-potha-was-product-of-much-effort-and-research-says-author-48132/

### *3.3 Acceptability of health services*

GC 14 defines acceptability in relation to respectfulness, medical ethics and cultural appropriateness of healthcare services, specifically that healthcare providers be "respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality…."[35]

Over a decade after the end of the civil war, and despite the Official Languages Commission Act (1991),[36] official Sinhala-Tamil bilingual language translators are not appointed to healthcare facilities. Although all healthcare providers in the public sector are required to pass an examination in the language that is not their mother tongue (Tamil or Sinhala), the former functions as a check box for promotion. There are no incentives for healthcare institutions or providers to adopt ethnicity or language-inclusive practices. Indeed, when a person who is unable to speak Sinhala seeks care at a healthcare facility in the South, they face numerous challenges, including castigation in the hands of healthcare providers.[37] The low priority given to issues of diversity within the healthcare system is magnified by the failure to address these concerns in health professional curricula, resulting in negative stereotyping and other discriminatory practices based on ethnicity/language against Tamil-speaking minorities.[38]

35. CESCR, 2000.
36. Official Languages Commission Act, No. 18 of 1991
37. Ramya Kumar, "The Privatization Imperative: Women Negotiating Healthcare in Kandy, Sri Lanka". PhD dissertation, (University of Toronto, 2018),https://tspace.library.utoronto.ca/bitstream/1807/82972/3/Kumar_Ramya_201803_PhD_thesis.pdf; D. Perera et al., "'When Helpers Hurt': Women's and Midwives' Stories of Obstetric Violence in State Health Institutions, Colombo District, Sri Lanka," BMC Pregnancy and Childbirth, 18(1), (2018) 1-12, https://doi.org/10.1186/s12884-018-1869-z
38. Ibid

While gender-responsiveness has been, to some extent, integrated into health professional curricula, initiatives to improve gender equality within the healthcare system are still to make ground. Incidents of sexual harassment/violence at the hands of healthcare providers are frequently reported in the media and also affect healthcare workers.[39] Muslim women encounter various forms of discrimination at public hospitals where they are often barred from wearing the abaya, hijab or niqab in the wards.[40] With no obligation to provide information, healthcare providers frequently carry out medical procedures without adhering to standard informed consent protocols. For instance, vaginal examinations are often carried out indiscriminately in public and private health sectors, at times against the wishes of women, constituting a form of sexual violence.[41]

Healthcare facilities, whether public or private, are rarely held accountable to healthcare users as mechanisms in place to provide redress are time-consuming and weak.[42] The Sri Lanka Medical Council (SLMC), which oversees standard setting and regulation and is mandated to protect the public from medical malpractice, is viewed to be partial, even by insiders.[43]

39. Emma .A. Adams, "Perceptions on the Sexual Harassment of Female Nurses in a State Hospital In Sri Lanka: A Qualitative Study," *Global Health Action,* 12 no1 (2019), 1560587.; "Captain Wanted in Gang Rape Case of Nurse Arrested," Daily News, Feb 16, (2018), https://www.dailynews.lk/2018/02/16/local/142961/captain-wanted-gang-rape-case-nurse-arrested

40. Ramya Kumar, "The Privatization Imperative: Women Negotiating Healthcare in Kandy, Sri Lanka," PhD [dissertation], (University of Toronto, 2018), https://tspace.library.utoronto.ca/bitstream/1807/82972/3/Kumar_Ramya_201803_PhD_thesis.pdf

41. Kanya D' Almeida, K , *The Darkest Light,* (2020-2022), https://thedarkestlight.buzzsprout.com/

42. P. Rupasinghe, "Medical Negligence and Doctor's Liability; A Critical Review in Present Legal Regime in Sri Lanka, 2015,http://ir.kdu.ac.lk/bitstream/handle/345/1394/law-043.pdf?sequence=1

43. Ruwandi Gamage, ," New Regulations Desperately Needed to Stop Doctor Malpractices," *Daily FT,* August 4, 2018, https://www.ft.lk/Front-Page/New-regulations-desperately-needed-to-stop-doctor-malpractices/44-660293

### *3.4 Quality of health services*

GC 14 interprets quality in terms of technical quality that is scientifically and medically sound services requiring "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[44] Although there is very little literature available regarding quality assurance processes implemented in the health sector, the levels of coverage achieved as well as the relatively good health outcomes—the latter influenced by a host of other health determinants—might suggest reasonable levels of quality of care.

Studies indicate more or less equal levels of quality of care in the public and private sectors.[45] While the public sector offers higher technical quality of services, including treatment and management in areas that are not constrained by resources, the private sector performs better interpersonal satisfaction and patient education.[46] Regardless of sector, quality of care is compromised by lacking space for patients to ask questions and be involved in their care.[47]

Moreover, as healthcare services are delivered in a largely unregulated environment, certain basic requirements remain unfulfilled. For instance, there are no minimal standards guiding consultation time and documentation, compromising continuity

44. CESCR, 2000.
45. Ravindra P. Rannan-Eliya et al., "Quality of Inpatient Care in Public and Private Hospitals in Sri Lanka," Health Policy and Planning, 30(suppl_1), (2015a), i46-i58.; Ravindra P. Rannan-Eliya et al., The Quality of Outpatient Primary Care in Public and Private Sectors in Sri Lanka—How Well Do Patient Perceptions Match Reality and What are the Implications? Health Policy and Planning, 30(suppl_1), (2015b) i59-i74.
46. Ibid.
47. Kanya D' Almeida, *The Darkest Light,* (2020 -2022),https://thedarkestlight.buzzsprout.com/ ; N. Soysa, Am I Ready to Die? (2021), https://www.youtube.com/watch?v=cwomFLADUCk

of care in both sectors. While instances of abuse, neglect, and discrimination in the hands of healthcare providers are widely reported, basic measures to ensure non-discrimination and make healthcare facilities inclusive for all, irrespective of class, ethnicity, gender, sexual orientation, disability, etc. are starkly absent.[48]

Having provided a broad overview of the extent to which the government respects, protects and fulfils the right to health in relation to 3AQ, the remainder of the chapter delves into specific rights concerns that trouble the health sector in Sri Lanka.

## 4. Young People's Sexual and Reproductive Health

Sexual and reproductive health (SRH) among adolescents and youth remains a low priority in Sri Lanka. Notwithstanding the National Strategic Plan on Adolescent and Youth Health 2018-2025,[49] which is comprehensive in scope, its implementation has been inconsistent in many areas. Access to basic SRH information for young people is limited. In 2020, a highly politicised controversy led to the withdrawing of a textbook on SRH titled, "Hathe Ape Potha," introduced to the Grade 7 health education curriculum. Sections of the Buddhist clergy protested the inclusion of material on masturbation, which they linked to attempts by external forces to destroy Sinhala Buddhist culture.[50] Despite attempts by the Ministry of Health to address

48. Dinusha Perera et al., "'When Helpers Hurt': Women's and Midwives' Stories of Obstetric Violence in State Health Institutions, Colombo District, Sri Lanka," *BMC Pregnancy and Childbirth,* 18, no1 (2018): 1-12, https://doi.org/10.1186/s12884-018-1869-z; N. Soysa, N. (2021). Am I ready to die? 2021, https://www.youtube.com/watch?v=cwomFLADUCk

49. Ministry of Health, n.d.

50. Rohana.R. Wasala, "Controversy about 'Hathe Ape Potha', A Supplementary Reader in Sinhala for Sexuality and Reproductive Health Education for Grade 7", *Lanka Web,* 2020, https://www.lankaweb.com/news/items/2020/03/06/controversy-about-hathe-ape-potha-a-supplementary-reader-in-sinhala-for-sexuality-and-reproductive-health-education-for-grade-7/

information and service gaps through the adolescent-friendly health services initiative, implementation has been piecemeal at best.[51]

Not surprisingly, SRH awareness is low among adolescents in Sri Lanka. A UNFPA-UNICEF survey carried out among 8,000 plus youth (15-24 years) across the island in 2013/2014 (the most recent) found that only 59% had received reproductive health education at school and 55% or less had knowledge about STIs, including how to prevent them.[52] Moreover, only 35% of those in school had knowledge on emergency contraception.[53] A prior survey conducted in the Kalutara district found that schoolteachers often skipped lessons on SRH and lacked the expertise and experience to teach sex education to young people.[54] Despite teenage pregnancy, unsafe abortion and rising HIV incidence being crucial public health problems, an alarming proportion of adolescents are sexually active without access to SRH information and services.[55]

The minimum age for marriage in Sri Lanka is 18 years with certain exceptions under customary law, the latter under a

51. "Protocol for Yowun Piyasa: Adolescent and Youth Friendly Health Service (AYFHS) Center", Family Health Bureau, 2018, https://fhb.health.gov.lk/images/FHB%20resources/Adolecent%20Health/Guideline/Protocol%20Yowun%20Piyasa/Protocol%20Yowun%20piyasa(pages%201-52).pdf ; M. Kumarasinghe& W.I. De Silva, W., "Adolescent and Youth Sexual and Reproductive Health in Sri Lanka: Are Policies and Strategies Geared to Address Issues?" *Asian Journal of Education and Social Studies* 29(1), (2022) 36-45. DOI: 10.9734/AJESS/2022/v29i130690

52. "The Need for Comprehensive Reproductive Health Education (CRHE) For Youth in Sri Lanka," UNFPA (2017). https://srilanka.unfpa.org/sites/default/files/pub-pdf/NEW%20CRHE%20Policy%20Brief%20%283%29_0.pdf

53. "The Need for Comprehensive Reproductive Health Education (CRHE) For Youth in Sri Lanka," UNFPA (2017). https://srilanka.unfpa.org/sites/default/files/pub-pdf/NEW%20CRHE%20Policy%20Brief%20%283%29_0.pdf

54. Ibid.

55. Ibid.

lengthy and contested reform process.[56] Sexual intercourse with an underage woman (less than 16 years) is considered statutory rape by law, except when the woman under 16 years is married. This law also applies to male "perpetrators" who are minors (less than 18 years of age).[57] This legislation surrounding statutory rape impedes access to SRH services for adolescents, in fear of law enforcement, an issue that was partially addressed by a 2015 Ministry of Health circular that permits healthcare providers to offer SRH information and services to adolescents.[58] However, few are aware of the circular and this group continues to have limited access to SRH services, making them vulnerable to unwanted pregnancy and its complications.

It is widely recognised that adolescents and youth need to be involved in the formulation of health policy and programmes for their success.[59] Yet, young people remain largely absent from decision-making forums on health in Sri Lanka. Arguably, this failure to engage young people converges with other factors to result in poor health outcomes, including teenage pregnancy, unsafe abortion, sexually transmitted infections (STI), substance use, and mental health problems.[60]

56. "What is the Muslim Marriage and Divorce Act (MMDA) 1951?" Muslim Personal Law Reform Action Group (n.d.). https://www.mmdasrilanka.org/faqs-about-the-mmda/
57. Imesha Madhubhani, "Statutory Rape Laws in Sri Lanka: The Underpinning Issues", *Sunday Observer,* September 10, 2017, https://www.sundayobserver.lk/2017/09/10/issues/statutory-rape-laws-sri-lanka-underpinning-issues
58. "Providing Sexual and Reproductive Health Services to Adolescents." Ministry of Health (2015a), http://www.health.gov.lk/CMS/cmsmoh1/viewcircular.php?cno=01-25/2015&med=english
59. "Engaging People for Health and Sustainable Development," WHO (2018), http://apps.who.int/iris/bitstream/handle/10665/274368/9789241514576-eng.pdf?ua=1
60. "National Strategic Plan on Adolescent and Youth Health (2018-2025).", Ministry of Health (n.d.),http://yowunpiyasa.lk/images/Guidelines/sp/SP.pdf

## 5. Women's Sexual and Reproductive Health

Sri Lanka is internationally acclaimed for providing universal and non-fee levying maternity care through its public healthcare system. Encompassing pre-pregnancy, pregnancy, delivery and postpartum care, the system has achieved an institutional delivery rate of 99% (95% in the public sector), with similar levels of skilled attendance at birth.[61] Public health midwives, who function as grassroots healthcare workers, register "eligible families" for service delivery, the latter comprising, by definition, not only married women, but also single pregnant women and households with young children.[62]

Family planning services are delivered free-of-charge through the National Family Programme. Available contraceptive methods include: oral contraceptive pills, injectables, implants, intra-uterine devices and female sterilisation. These services are delivered at community clinics and/or hospitals; condoms and oral contraceptive pills are also distributed to "eligible families" by public health midwives during home visits.[63] Yet, single working women (and men) are effectively excluded from these services as they do not fulfil the criteria of "eligibility." Moreover, social sanctions against sex before marriage and inconvenient (morning) public sector service hours drive many to the private sector, usually pharmacies, which provide limited SRH information.[64]

61. "Demographic and Health Survey 2016", Department of Census and Statistics , 2017. http://www.statistics.gov.lk/Health/StaticalInformation; Sri Lanka RMNCAH fact sheet July 2018, WHO SEARO (2018). https://cdn.who.int/media/docs/default-source/maternal-health/rmncah-fs-srl.pdf?sfvrsn=9263909d_2

62. "Annual Report of the Family Health Bureau 2019," Family Health Bureau (2021), https://drive.google.com/file/d/1j3KdkBN0cwueRB9opmYsJN_03tNGvwDz/view

63. Ibid.

64. Bakamoono, "Contraception in Sri Lanka: An Insight," 2021,http://www.bakamoono.lk/admin/wp-content/uploads/2016/06/Bak-Contraceptive-Survey-Report_Feb2021.pdf

The mix of contraceptive methods used by women varies across urban/rural sector and education level. Notably, the use of long-acting reversible contraceptive methods and female sterilisation is much higher among estate and rural sector women compared to educated urban women, who opt for "natural" family planning, raising questions around autonomy and choice.[65] This situation is compounded by the fact that a significant proportion of women do not receive adequate information from contraceptive service providers.[66] Moreover, women in Sri Lanka encounter new restrictions in relation to accessing contraception, quite different from the population control strategies of yesteryear.[67] Driven by ethnonationalist preoccupations among Sinhala Buddhist factions regarding the growth of the Muslim population, Sinhala women's requests for sterilisation are frequently turned down, even when they fulfil the criteria of the national policy on sterilisation: women above 26 years of age with two children, the younger having to be at least two years.[68] Following the 2019 Easter bombings and the much publicised, and fabricated, allegations of a Muslim doctor conducting sterilisations without consent on Sinhala women following Caesarean section, this situation worsened (personal communication with a local public health expert).

Another women's health issue that has been left on the backburner for far too long is abortion, which is criminalised in Sri Lanka except under lifesaving circumstances. The restrictive legal

65. Bakamoono, "Contraception in Sri Lanka: An Insight," 2021.
66. "Demographic and Health Survey 2016," Department of Census and Statistics, September, 2017.http://www.statistics.gov.lk/Health/StaticalInformation
67. Sasikumar Balasundaram, "Stealing Wombs: Sterilization Abuses and Women's Reproductive Health in Sri Lanka's Tea Plantations, *Indian Anthropologist,* 41, no2 (2011): 57-78.
68. "Eligibility for Sterilization," Family Health Bureau (1988), https://www.fhb.health.gov.lk/images/FHB%20resources/Family%20Planning/Family%20Planning%20Unit/Circulars/Eligibility%20for%20Sterilization%20general%20circular%20no%201586.pdf

environment compels socially and economically disadvantaged women to seek abortion services under unsafe conditions, while others access (safe) services in the private sector.[69] Medical professionals play a gatekeeping role when it comes to abortion. Misoprostol, a drug used for medical abortion—registered in 2015 by the National Medicines Regulatory Authority after a lengthy and disputed registration process—is now available at public hospitals, but only for indications other than induced abortion, when prescribed by an obstetrician/gynaecologist (OBGYN).[70] Misoprostol is widely available in the black market, but access is limited to women who are directed to pharmacies through trusted contacts, often private OBGYNs, for a fee. Relatedly, the criterion of "saving a mother's life" may be interpreted variously, enabling some categories of women, such as adolescent survivors of rape or incest, to access abortion services at public hospitals (personal communication with an OBGYN practicing in Sri Lanka). Efforts to liberalise abortion law have reached an impasse with reforms targeting instances of rape and incest facing strident opposition from religious quarters,[71] in spite of post-abortion sepsis being an important cause of maternal mortality.[72] The Ministry of Health's guidelines on post-abortion care (PAC) seek to ensure access to

69. Ramya Kumar, "Abortion in Sri Lanka: The Double Standard," *American Journal of Public Health,* 103, no.3 (2013): 400-404.

70. Ramya Kumar, "Misoprostol and the Politics of Abortion in Sri Lanka," *Reproductive Health Matters,* 20 ,no 40 (2012): 166-174; "National Guideline on Use of Misoprostol in Gynaecology and Obstetrics," Ministry of Health (2021), https://drive.google.com/file/d/12UjgbofQ06Zfrhmg hASNrK7WLWOKdApU/view

71. Kingsley Karunaratne, "Buddhist, Muslim and Christian Leaders Oppose Abortion," *UCAnews,* 2017, https://www.ucanews.com/news/buddhist-muslim-and-christian-leaders-oppose-abortion/80326

72. "Annual Report of the Family Health Bureau 2019," Family Health Bureau (2021), https://drive.google.com/file/d/1j3KdkBN0cwueRB9opmYsJN_03tNGvwDz/view

compassionate care for women following abortion,[73] but those who access PAC often encounter healthcare providers who lack empathy and gender sensitivity.[74]

In 2019, the Ministry of Health launched a policy on the prevention and management of gender-based violence (GBV). Although this effort is commendable, with no dedicated GBV prevention staff, the already over-burdened Medical Officer of Health (MOH) and public health midwives are tasked with its implementation.[75] The MithuruPiyasa/NaptuNilayam centres, now located at secondary and tertiary hospitals, offer befriending and counselling, and also refer service users, as and when required, for legal services.[76] According to a Women's Wellbeing Survey carried in out in 2019, only a small minority of perpetrators are held to account for GBV in Sri Lanka.[77]

The Family Health Programme of the Ministry of Health, which purveys maternal and child health services, including family planning, places men peripherally, assigning the primary responsibility for pregnancy and childbirth to women.[78] Although a few initiatives have commenced in the public sector

73. "National Guidelines on Post-Abortion Care," Ministry of Health (2015b), http://fhb.health.gov.lk/images/FHB%20resources/Family%20Planning/Family%20Planning%20Unit/Publications/National%20Guidelines%20on%20Post%20%20%20Abortion%20Care.pdf

74. Sophie Cousins, "Sri Lankan Women too Scared to Seek Legal Post-Abortion Care," The *New Humanitarian,* 11 Dec 2017. https://deeply.thenewhumanitarian.org/womenandgirls/articles/2017/12/11/sri-lankan-women-too-scared-to-seek-legal-post-abortion-care; "Fighting for Safe Abortion Access in Sri Lanka", International Planned Parenthood Federation (IPPF), 2019 https://www.ippf.org/blogs/fighting-safe-abortion-access-sri-lanka

75. "Health Sector Response to Gender-Based Violence Sri Lanka 2019," Family Health Bureau (2019); Standard Operating Procedures for First Contact Point Health Care Providers, https://srilanka.unfpa.org/sites/default/files/pub-pdf/Standard%20Operating%20Booklet.pdf

76. Ibid.

77. "Women's Wellbeing Survey 2019 – Sri Lanka," Department of Census and Statistics (2020), http://www.statistics.gov.lk/Resource/refference/WWS_2019_Final_Report

78. "Health Sector Response to Gender-Based Violence Sri Lanka, Standard Operating Procedures for First Contact Point Health Care Providers," Family Health Bureau (2019); https://srilanka.unfpa.org/sites/default/files/pub-pdf/Standard%20Operating%20Booklet.pdf

to involve men in parenting, such as a package of services for "newly married couples" and antenatal health education sessions that encourage spousal participation, the clinic and hospital set up, remain unwelcoming. Men are not permitted to participate in the delivery at public hospitals given the unavailability of private delivery rooms.[79]

## 6. LGBTIQA+ People

LGBTIQA+ communities face various forms of discrimination, harassment and abuse with wide ranging health consequences. While Section 365 of the Penal Code criminalises intercourse "against the order of nature," Section 399 criminalises impersonation and the Vagrants' Ordinance prohibits soliciting and acts of "gross indecency." This legislation is frequently used to arrest LGBTIQ people. Apart from the law, entrenched gender norms reinforce negative stereotypes and societal attitudes towards gender non-conforming people.[80]

In Sri Lanka, coming out as LGBTIQA+ is challenging. Conversion therapy is widely practiced and routinely recommended by doctors, both indigenous and allopathic,[81] resulting in serious harm.[82] For transgender persons, gender transitioning services, including hormone therapy and sex reassignment surgery, are available at public hospitals, albeit with urban-rural inequities in access.[83] In 2016, the Ministry of Health launched a system

79. Kanya D' Almeida, (2020-2022), *The Darkest Light.* https://thedarkestlight.buzzsprout.com/
80. "All Five Fingers Are Not the Same", Human Rights Watch, 2016, https://www.hrw.org/sites/default/files/report_pdf/srilanka0816web.pdf
81. Conversion therapy Practices in Sri Lanka, Asia Pacific Transgender Network (2021). https://weareaptn.org/wp-content/uploads/2021/03/Conversion-Therapy-2020-SriLanka_28Dec.pdf
82. "AnalyzingThe Culture of Transphobia", Equal Ground (2015). https://www.equal-ground.org/wp-content/uploads/Trans-Gender-Report-.pdf; All Five Fingers Are Not the Same, Human Rights Watch, 2016.
83. "All Five Fingers Are Not the Same", Human Rights Watch, 2016

to issue gender recognition certificates to transgender people after assessment by a consultant psychiatrist with the Ministry of Health.[84]

Accessing gender transitioning procedures in Sri Lanka involves stigma and discrimination, and there are no guarantees of privacy or confidentiality.[85] Those who have undergone these procedures report being treated like specimens on exhibition, especially at public hospitals. Health professional curricula tread lightly on transgender health, resulting in healthcare providers being ignorant in this area, with many asking intrusive questions. Surgery is often undertaken by inexperienced surgeons with inadequate training in sex reassignment procedures.[86] Given these circumstances, those who can afford it, access services in the private sector, paying very steep fees. Overall, the weak regulatory environment and lack of accountability in healthcare leaves the trans community vulnerable to various forms of malpractice and exploitation, regardless of sector.[87]

## 7. Sex Workers

Sex workers represent another group that faces significant health challenges. An estimated 35,000 to 40,000 sex workers offer services in Sri Lanka.[88] Yet, the Vagrant Ordinance (1841)

84. "Issuing of Gender Recognition Certificate for Transgender Community." Ministry of Health. 2016, http://www.health.gov.lk/CMS/cmsmoh1/viewcircular.php?cno=01-34/2016&med=english
85. "All Five Fingers Are Not the Same", Human Rights Watch, 2016.;
"Analyzing The Culture of Transphobia, Equal Ground," 2015, https://www.equal-ground.org/wp-content/uploads/Trans-Gender-Report-.pdf;"
86. All Five Fingers Are Not the Same", Human Rights Watch, 2016.;
"Analyzing The Culture of Transphobia," Equal Ground, 2015.
87. "All Five Fingers Are Not the Same", Human Rights Watch, 2016.;
"Analyzing The Culture of Transphobia," Equal Ground, 2015.
88. I. Bozicevicet al., "Estimating the Population Size of Female Sex Workers and Transgender Women in Sri Lanka." *PloS one,* 15 no 1 (2020) e0227689.

provides for the arrest of "every common prostitute wandering in the public street" and also criminalises soliciting.[89] While these "crimes" are legally difficult to prove, law enforcement authorities frequently make arrests on the grounds of possessing condoms as proof of sex work,[90] serving to discourage sex workers from carrying condoms. Indeed, a substantial proportion of sex workers report not using condoms during sexual intercourse with clients, with serious implications for STI prevention.[91] In the health sector, sex workers face considerable stigmatisation and stereotyping, and, at times, are even denied essential healthcare, including maternity services.[92] The pandemic presents a unique set of challenges for sex workers, driving many to financial hardship.[93]

## 8. People living with HIV (PLWHIV)

With <0.1% of adults aged 15 to 49 years affected, Sri Lanka records low (but steadily climbing) HIV prevalence.[94] The public

89. "Laws Concerning Commercial Sex and HIV/AIDS Prevention", National STD/AIDS Control Programme& UNFPA (n.d.), http://www.aidscontrol.gov.lk/images/pdfs/books/Laws_Concerning_en.pdf

90. "Status of Women Sex Workers in Sri Lanka," Abhimani Women's Collective, The Stand Up Movement Lanka, Praja Diri Padanama, Community Strength Development Foundation & Women's Resource Centre, 2017, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT_CEDAW_NGO_LKA_26289_E.pdf

91. Ariyaratne Manathunge et al., "HIV Prevalence, Sexual Risk Behaviours and HIV Testing Among Female Sex Workers in Three Cities in Sri Lanka: Findings from Respondent-Driven Sampling Surveys," *PloS one,* 15(10), 2020, e0239951.

92. "Status of Women Sex Workers in Sri Lanka," Abhimani Women's Collective, The Stand Up Movement Lanka, Praja Diri Padanama, Community Strength Development Foundation & Women's Resource Centre, 2017, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT_CEDAW_NGO_LKA_26289_E.pdf

93. Himal Kotelawala, "Sri Lanka's Sex Workers Struggle to get by as COVID-19 Brings Industry to A Halt," *Economy Next,* 2020, https://economynext.com/sri-lankas-sex-workers-struggle-to-get-by-as-COVID-19-brings-industry-to-a-halt-70850 /

94. "HIV/AIDS Surveillance Data in Sri Lanka – Update 2nd Quarter 2022", National STD/AIDS Control Programme (2022). http://aidscontrol.gov.lk/images/HIV_2ndQ_2022.pdf; UNAIDS data ,2021, https://www.unaids.org/en/resources/documents/2021/2021_unaids_data

system provides universally accessible comprehensive diagnostic and treatment services for HIV/AIDS. Although PLWHIV report positive experiences at HIV treatments centres, often stigmatizingly called "STD clinics" or "Room 33" (the latter refers to the room designated for STI-related consultations at the outpatient department of the Colombo National Hospital), most do not disclose their HIV status during other encounters with healthcare, in fear of stigma and discrimination.[95]

These deep-rooted fears are held with reason. Despite few disclosing their HIV status to healthcare providers, a 2017 survey among a representative sample of 150 people living with HIV in Sri Lanka found that 3% had experienced verbal abuse from healthcare providers.[96] With respect to HIV testing, only half the sample (49%) had received pre- and post-testing counselling, and about 40% were not even informed when they were tested, with 2% tested against their wishes.[97] A substantial proportion of survey participants reported having decided to abstain from sex (30%), not have children (27%) or not get married (20%), reflecting both societal perceptions of HIV/AIDS and internalised stigma.[98] Indeed, 20% of the sample reported suicidal ideation, and about twice as many responded that their family was a barrier to accessing HIV services.[99]

95. Stigma Assessment of People Living with HIV in Sri Lanka, National STD/AIDS Control Programme (n.d.). https://www.aidsdatahub.org/sites/default/files/resource/stigma-assesment-plhiv-sri-lanka-2017.pdf
96. Ibid
97. Ibid
98. Ibid
99. Ibid

## 9. People with Disabilities

Despite the Protection of the Rights of Persons with Disabilities Act of 1996 and disability accessibility regulations in effect since 2006, healthcare access for people with disabilities remains an unresolved problem in the health sector.[100] For one, the total lack of disability accessible transport prevents many people with disabilities, especially the poor, from accessing healthcare. Most outpatient settings, including public primary care facilities, channelling centres, private dispensaries, laboratories, and community pharmacies, do not have even the most basic infrastructure to enable people with disabilities to navigate healthcare services independently. Although ramps and elevators are generally available at hospitals, disability accessible washrooms are scarce at most healthcare institutions. The (limited) adjustments that have been made to the built environment mostly address physical disability; the lack of sign language and audio-visual media services impede access for people with visual and hearing impairment.[101]

Negative stereotyping by healthcare providers results in persons with disability being overlooked for SRH services, and at times being discouraged from having children.[102] The lack of educational opportunities and institutionalised discrimination against children with disabilities in the education sector, reflects

100. Pieris-John et al., "Disability Studies in Sri Lanka: Priorities for Action", *Disability and Rehabilitation,* 36 no20 (2014): 1742-1748.
101. Lakshila Wanigasinghe, Leave No One Behind: Building a Disability-Inclusive COVID-19 Recovery Plan for Sri Lanka, 2021, https://www.ips.lk/talkingeconomics/2021/08/16/leave-no-one-behind-building-a-disability-inclusive-COVID-19-recovery-plan-for-sri-lanka
102. "People with Disabilities Not Getting Sexual and Reproductive Health Services – UNFPA." *Economynext,* 2020, https://economynext.com/people-with-disabilities-not-getting-sexual-and-reproductive-health-services-unfpa-53473/

societal attitudes toward people with disabilities, with critical impacts on health and social wellbeing.[103]

## 10. Elderly People

Demographic projections foretell a steep rise in the elderly population in coming decades, from 9.4% in 2015 to 21% by 2045.[104] Yet, elderly care is poorly developed in Sri Lanka. In the absence of community-based long-term care for the elderly, they must rely on public hospitals that are not tailored to address their needs. For instance, the health sector's disability (in)accessibility is a serious concern for the elderly, and the healthcare system is not set up to offer care for specific conditions that affect elders, such as dementia, a growing problem with huge social consequences.

Elderly care services must go hand in hand with social and occupational support, which are also largely absent. The Department of Social Services has neither the resources nor a system in place to support independent or assisted living among the elderly, who are still mostly cared for (albeit at times neglected) by their families. Under difficult circumstances, some families are compelled to resort to institutionalised care. Public sector elderly homes are scarce and generally reserved

103. UN Universal Periodic Review - Sri Lanka 2017 Third Cycle, 28th Session 2017; Submission for the Review of the Situation of Persons with Disabilities in Sri Lanka, Disability Organisations Joint Front, 2017, https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/RightAccessJusticeArticle13/CSO/DisabilityOrganizationsJointFrontSrilanka.pdf; Ramya Kumar," Education for Some but Not for Others: Learning Support, Disability and Free Education," Island, 2021, https://island.lk/education-for-some-but-not-for-others-learning-support-disability-and-free-education/

104. "Growing Old before Becoming Rich: Challenges of an Aging Population in Sri Lanka", (Asian Development Bank 2019). https://www.adb.org/sites/default/files/publication/557446/aging-population-sri-lanka.pdf

for those with no family support.[105] Private homes are of varying quality and standards. Because the government lacks an effective mechanism to monitor these services, elderly persons are exposed to extortion and other forms of exploitation, even at healthcare settings.[106]

## 11. Selected Health Issues of Concern

### *11.1 COVID-19*

Sri Lanka has an impressive track record in the control of communicable diseases. Between 2018 and 2020, the World Health Organisation (WHO) certified Sri Lanka as being free of measles (2019), congenital rubella syndrome (2020) and mother-to-child of HIV (2020), on the heels of polio (2014) and malaria elimination (2016).[107] Many of these achievements are attributed to the highly successful (non-fee levying) National Immunisation Programme, delivered alongside maternal and child health services at the grass roots level.[108]

Despite these successes, in early 2020, the government placed the national COVID-19 pandemic response in the hands of the military. Admittedly, the government did expand COVID-19 testing, contact tracing and treatment facilities within a short space of time. However, the COVID-19 response came under scrutiny for its aggressive surveillance strategy that targeted low-income groups and ethnic minorities, particularly Muslim communities.

105. Ibid
106. Ibid
107. B. J. C. Perera, "Elimination of Several Infectious Diseases from Sri Lanka: A Tribute to the Parents of our Children and to Our Immunisation Programme," *Sri Lanka Journal of Child Health 49*, no 4(2020): 317-319. https://sljch.sljol.info/articles/10.4038/sljch.v49i4.9260/galley/6878/download/
108. Ibid

Even the Government Medical Officers' Association (GMOA)'s initial proposals for a COVID-19 exit strategy included the size of the Muslim population in an administrative division as a variable for risk stratification.[109]

To make matters worse, the Ministry of Health issued a controversial mandatory cremation policy after a COVID-19 death—contrary to WHO recommendations and international practice—drawing widespread protest from human rights groups.[110] Against the religious beliefs of Muslims, the policy was justified on the grounds that COVID-19 burials would contaminate ground water, and remained in place until early 2021, after which, as a result of international pressure, burial was permitted in a designated area in the Eastern Province.[111] The dead were returned to their families as per pre-pandemic practice only in early 2022, owing to international pressures in the context of the economic crisis.

Arbitrary arrests of social media activists became common place in the early months of the pandemic, after the IGP instructed the Police to take strict action against those who criticise Government officials engaged in COVID-19 control. While the details of these arrests are still not known, social medial activist Ramzy Razee kwas arrested for inciting religious disharmony under the International Covenant on Civil and Political Rights (ICCPR) Act after posting a social media call for an 'ideological

109. Ramya Kumar "Beyond Numbers: Sri Lanka's COVID-19 Response, Politics and People," *Polity 8* (1&2), 2020, 8-13. http://repo.jfn.ac.lk/med/bitstream/701/2368/1/Beyond-Numbers-.pdf
110. Ibid
111. "Sri Lanka Buries First COVID Victims after Long Standoff," *NDTV,* March 5, 2021, https://www.ndtv.com/world-news/sri-lanka-buries-first-COVID-victims-after-long-standoff-2384649

Jihad' to counter anti-Muslim propaganda.[112] A few weeks later, the Human Rights Commission of Sri Lanka[113] expressed concerns about arbitrary arrests, including the use of the ICCPR Act in a targeted manner. While the mental health consequences of such arrests were dire, Razeek suffered medical complications in prison.[114]

As the incidence of COVID-19 increased among prisoners, a spate of prison riots brought attention to the appalling conditions in the country's prison system. In November 2020, eight prisoners at the Mahara jail were killed as prison guards opened fire during a protest over COVID-19 spread in the prison.[115] A report on Sri Lankan prisons published by HRCSL,[116] reported excessive congestion and a general lack of basic facilities, including safe food, water and sanitation, "amounting to inhuman living conditions."[117] With respect to healthcare, the report drew attention to inadequate infrastructure and acute shortfalls of prison healthcare workers, resulting in delays in the provision of medical care. The HRCSL also highlighted that certain groups of prisoners were made more vulnerable by these conditions,

112. Damith Chandimal & Ruki Fernando, "Free Expression, Hunger and Racism in Context of COVID-19," *Groundviews,* April 14, 2020, https://groundviews.org/2020/04/14/free-expression-hunger-and-racism-in-context-of-COVID19/

113. "Sri Lanka HRC writes to IGP: Limiting freedom of expression in a democracy needs to strike a lawful balance," Sri Lanka Brief, April 27, 2020, https://srilankabrief.org/sri-lanka-hrc-writes-to-igp-limiting-freedom-of-expression-in-a-democracy-needs-to-strike-a-lawful-balance

114. "Sri Lanka: Health Concerns for Detained blogger: Ramzy Razeek," Amnesty International, 2020. https://www.amnesty.org/en/documents/asa37/2357/2020/en/

115. "Sri Lanka Prisoners Killed in Riot over Coronavirus Conditions," *The Guardian,* November 30, 2020, https://www.theguardian.com/world/2020/nov/30/sri-lanka-prisoners-killed-in-riot-over-coronavirus-conditions

116. "Prison Study by the Human Rights Commission of Sri Lanka," Human Rights Commission of Sri Lanka, 2020, https://www.hrcsl.lk/wp-content/uploads/2020/01/Prison-Report-Final-2.pdf

117. Ibid p. vi

including "prisoners on death row, women, young offenders, foreign nationals, prisoners detained under the Prevention of Terrorism Act and prisoners with disabilities."[118]

### *11.2 NCDs, mental health and illness*

The Ministry of Health's approach to NCD control focuses on early identification and treatment of NCDs and, to a lesser extent, primary prevention through lifestyle modification.[119] Despite an epidemic of NCDs—the number one cause of death in Sri Lanka[120] –public health teams have no dedicated staff to address the problem. NCD screening is, to some extent, promoted by public health inspectors, but they are heavily burdened by commitments to infectious disease control.[121]

Although unhealthy diets are a key risk factor for NCDs and obesity and other metabolic risk factors, such as high blood sugar and high cholesterol, are on the rise, the government has failed to take adequate measures to regulate the food industry. The Food Act of 1980 largely focuses on food sanitation with far less attention to legislation to protect the public from NCDs.[122] The few public health interventions designed to control NCDs, place the onus on people: in 2016, the Ministry of Health introduced a traffic light labelling system for sugar-sweetened beverages and in 2019 for commercially packaged foods.[123] Yet, there is no

118. Ibid p. iii
119. "Circulars and Guidelines," Directorate of NCD, 2022, https://www.ncd.health.gov.lk/index.php?option=com_content&view=article&id=14&Itemid=142&lang=en
120. "Health Data, Sri Lanka," IHME, https://www.healthdata.org/sri-lanka
121. "Manual for the Sri Lanka Public Health Inspector", Ministry of Health, 2010,https://phi.lk/Manual_for_the_Sri_Lanka_PHI.pdf
122. "Food Control Administration Unit,2022a," Food Act. https://eohfs.health.gov.lk/food/index.php?option=com_content&view=article&id=17&Itemid=158&lang=en
123. Food Control Administration Unit, 2022b, Current Regulations,https://eohfs.health.gov.lk/food/index.php?option=com_content&view=article&id=18&Itemid=159&lang=en

regulation in place to limit the expansion of fast-food chains or the marketing of unhealthy foods to children and adolescents. On a positive note, however, the Government has long supported policies banning the advertisement of formula milk for infants,[124] and implemented strong anti-tobacco legislation.[125]

Psychiatric services are delivered across the country through specialist psychiatry units at public hospitals. A designated medical officer based at the Office of the Regional Director of Health Services (RDHS) oversees mental health services within each district. These services are targeted to people with psychiatric illness and community outreach services are under development for this group. However, community-based mental health promoting services, including for school-going adolescents and the elderly, are poorly developed or non-existent.[126] Similar to NCDs, there are no cadres to promote mental health in the Medical Officer of Health (MOH) system.

Mental health is inadequately addressed in the School Health Programme and health education curricula. Although school counsellors are appointed by the Department of Education, service quality and, consequently, utilisation varies, with stigmatisation an ongoing concern.[127] Some of these gaps are filled by non-government organisations, but they tend to provide

124. "Sri Lanka Code for the Promotion, Protection and Support of Breastfeeding and Marketing of Designated Products," Government of Sri Lanka ,2004, http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/list_publi/act/Act-BreastFeeding-English.pdf

125. "Legislation by Country: Sri Lanka, Campaign for Tobacco Free Kids", 2022, https://www.tobaccocontrollaws.org/legislation/country/sri-lanka/summary#:~:text=The%20law%20prohibits%20the%20sale,under%20the%20age%20of%2021.

126. Kathriarachchi et al., "Development of Mental Health Care in Sri Lanka: Lessons Learned," *Taiwanese Journal of Psychiatry,* 33 no 2(2019): 55-65, DOI: 10.4103/TPSY.TPSY_15_19.

127. H. K. H. Jayawardena& G. P. Gamage "Exploring Challenges in Mental Health Service Provisions for School-Going Adolescents in Sri Lanka," *School Psychology International,* 43, no1 (2022): 18-37

patchy service coverage. The neglect of adolescent mental health is reflected in the rising incidence of mental health issues among adolescents and young people.[128]

### *11.3 Occupational health and safety*

Livelihoods are critical for health, whether through their direct effects on physical and mental health or through their influence on income and social wellbeing. Despite such importance, occupational health and safety legislation remains weak in Sri Lanka.[129] Much of the informal sector is not covered by the legislation, and where applied, implementation has been ineffective.[130] New legislation, in draft stage for years, is yet to be passed by the Parliament.[131]

The Factory Ordinance (1942) remains the primary piece of legislation governing occupational health and safety. It requires reporting of occupational accidents and diseases, but underreporting is widespread with very few who sustain injury or disease receiving any form of compensation from employers. A study of construction companies found that among the 22 companies surveyed, over two-thirds had no occupational health

128. T. Rajapakse "Minimizing Self-Harm Among Adolescents and Young People," In *Suicide Prevention in Sri Lanka: Recommendations for Action,* Sri Lanka Medical Association, 2019, 52-59, https://slma.lk/wp-content/uploads/2020/10/Suicide-Prevention-in-Sri-Lanka-Recommendations-for-Action-final.pdf

129. Work Safety and Security, *Daily FT,* February 1, 2021, https://www.ft.lk/ft_view__editorial/Work-safety-and-security/58-712356

130. Arnold et al., "Occupational Hazards in Medium and Large-Scale Industrial Sectors in Sri Lanka: Experience of a Developing Country", BMC Research Notes, 12, no1(2019): 1-5; A.T. Onni, (2021). Work and Health in the Coir Industry in Sri Lanka: A Descriptive Study with a Specific Focus on Risk Factors for Injuries and Incidence of Injuries at these Workplaces [MPhil thesis]. University of Bergen. https://bora.uib.no/bora-xmlui/bitstream/handle/11250/2834972/Anindita-Coir.pdf?sequence=1&isAllowed=y

131. Work Safety and Security, *Daily FT,* February 1, 2021, https://www.ft.lk/ft_view__editorial/Work-safety-and-security/58-712356

and safety policy and about three-fourths did not provide health and safety training to their workers.[132] With the post-war boom in the construction industry, fatal falls from heights among construction workers are widely reported in the media.[133]

Despite the legislation in place, workplace hazards are weakly monitored and controlled. A study conducted in the Biyagama Export Processing Zone in the Western Province found numerous physical hazards, unsafe machinery and inadequate safety measures in many work settings.[134] During the pandemic, garment factory workers were compelled to work amid spreading COVID-19.[135] Owing to widespread union-busting practices at EPZs, workers have very little negotiating power to demand healthy and safe work conditions.[136]

### *11.4 Social and structural determinants of health*

GC 14 highlights the importance of addressing the underlying determinants of health, including safe water, sanitation, food, nutrition, housing, work and the environment. These aspects are usually neglected in discussions on the right to health where the focus tends to be on the healthcare system. Social determinants

132. W.D. Darshana, "Improvement of Health and Safety in Construction Sites in Sri Lanka," Engineer: *Journal of the Institution of Engineers,* Sri Lanka, 1(50), 2017, 53-70.

133. "Worker Dies after Falling in Lift Shaft of Lotus Tower," *Ada Derana,* 2018, http://www.adaderana.lk/news/47962/worker-dies-after-falling-in-lift-shaft-of-lotus-tower; Daily Mirror (2019). "Construction Worker Falls to Death from Hotel Building", *Daily Mirror,* April 9, 2019, https://www.dailymirror.lk/breaking_news/Construction-worker-falls-to-death-from-hotel-building/108-165226

134. Arnold et al., "Occupational Hazards in Medium and Large-Scale Industrial Sectors in Sri Lanka: Experience of a Developing Country", *BMC Research Notes,* 12(1), 2019, 1-5.

135. "Sri Lanka: Protect Garment Workers' Rights During Pandemic," HRW (2021), https://www.hrw.org/news/2021/07/12/sri-lanka-protect-garment-workers-rights-during-pandemic

136. "Overworked and Underpaid, Sri Lanka's Garment Workers left Hanging by a Thread: Workplace Issues in the Sri Lanka Garment Sector," Solidarity Centre, 2021,https://www.solidaritycenter.org/wp-content/uploads/2021/11/Workplace-Issues-in-the-Sri-Lanka-Garment-Sector.10.2021.FINAL_.pdf

of health (SDOH), as defined by the WHO Commission on SDOH,[137] are broad in scope and include the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." Since the Commission's report, however, SDOH have been operationalised with less attention to the social relations, such as class, race or gender that structure/pattern health and illness.[138] This section briefly considers the structural determinants of health with reference to water, sanitation and nutrition in Sri Lanka.

According to national statistics, over 90% of households in Sri Lanka have access to safe drinking water and sanitation.[139] These aggregate statistics mask significant regional disparities. For instance, only 54% of households in NuwaraEliya, a tea plantation district and home to the deprived Malaiyaha community, have access to clean water when compared with 99.9% in Colombo.[140] Moreover, the availability of piped water and piped sewerage systems is far lower across the island with only 36% and 2%, respectively, having access to these facilities.[141]

High and persistent rates of malnutrition disproportionately affect rural and plantation districts in Sri Lanka. The most recent DHS 2016 reported that: 21% of children <5 years across the

137. "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Commission on Social Determinants of Health Final Report," WHO Commission on Social Determinants of Health &, World Health Organization, 2008https://apps.who.int/iris/bitstream/handle/10665/43943/97892?sequence=1

138. Crear-Perry et al., "Social and Structural Determinants of Health Inequities in Maternal Health", *Journal of women's health,* 30(2), 2021, 230-235.

139. "World Bank Open Data", World Bank ,2022,https://data.worldbank.org/

140. Ibid

141. "Sri Lanka Needs New Water and Sanitation Policies to Unlock Investment Barriers," World Bank, 2021, https://www.worldbank.org/en/news/feature/2021/08/31/sri-lanka-needs-new-water-and-sanitation-policies-to-unlock-investment-barriers#:~:text=According%20to%20the%20Sri%20Lanka,and%202%25%20to%20piped%20sewerage

island are underweight (30% in the NuwaraEliya district); 15% children <5 years are wasted (24% in the Moneragala district); and 17% of children <5 years are stunted (32% in the Nuwara Eliya district).[142] The higher levels of malnutrition in rural and plantation districts suggest that malnutrition is closely linked with poverty and the unavailability of nutritious food.

Anaemia is widespread with 25% of children <5 years and 35% of women of reproductive age having anaemia in 2019.[143] An island-wide survey from 2006 (the most recent national survey) found a social gradient in the prevalence of moderate to severe anaemia among children <5 years where the lowest wealth quintile had the highest prevalence (39.9%) compared with the second (39.2%), middle (30%), fourth (29.6%) and highest (26.4%) quintiles, respectively. Similar differences were identified among non-pregnant women of reproductive age where 17.2% of the lowest wealth quintile and 10.7% of the highest wealth quintile were affected by moderate to severe anaemia[144] (Department of Census and Statistics, 2009). Numerous nutrition-specific health sector interventions address malnutrition, including promoting exclusive breastfeeding, healthy complementary feeding, protein-energy and micronutrient supplementation, as well as targeted in-kind benefits for pregnant women. However, malnutrition rates have remained resistant to such interventions, suggesting that broader welfare measures that address social and economic wellbeing may be needed.

142. "Demographic and Health Survey 2016," Department of Census and Statistics ,2017, http://www.statistics.gov.lk/Health/StaticalInformation

143. "World Bank Open Data", World Bank, 2022, https://data.worldbank.org/

144. "Prevalence of Anaemia among Children and Women Demographic and Health Survey 2006/7," Department of Census and Statistics, Dec 2009, http://www.statistics.gov.lk/Resource/en/Health/PrevalenceOfAnaemiaAmongChildrenANDWomenInSriLanka.pdf

## 12. Obscuring health disparities

The right to health, as interpreted by the CESCR, emphasizes equity and non-discrimination. In order to measure health inequity (or avoidable differences in access or outcomes), health information systems must be designed to collect data on social class/socioeconomic status, sex/gender, ethnicity, sexuality, disability and other variables. In Sri Lanka, for the most part, health information systems do not collect these data. The DHS considers age group, education level, urban/rural/estate sector, district of residence and wealth quintile,[145] but disease surveillance systems only elicit a bare minimum, usually age, sex and district of residence.

Even after Sri Lanka's 30-year civil war, which ended in 2009, data are not disaggregated by ethnicity. In the rare instances they are, clear disparities are discernible. In 2021, the Family Health Bureau reported maternal mortality by ethnicity for the year 2019; over a third (34%) of dead women represented ethnic minorities (Tamil 20%, Muslim 14%)[146], a higher proportion than their representation in the general population (24%; Tamil 15% and Muslim 9%).[147] Notably, the Family Health Bureau did not breakdown the category 'Tamil' into Sri Lankan and Indian Tamil—considered distinct ethnic groups in the Census. This omission may serve to mask wider inequity as the highest rates of maternal mortality are usually reported from plantation districts,

145. "Demographic and Health Survey 2016," Department of Census and Statistics ,2017, http://www.statistics.gov.lk/Health/StaticalInformation
146. "Annual Report of the Family Health Bureau 2019," Family Health Bureau, 2021, https://drive.google.com/file/d/1j3KdkBN0cwueRB9opmYsJN_03tNGvwDz/view
147. "Demographic and Health Survey 2016," Department of Census and Statistics ,2017,http://www.statistics.gov.lk/Health/StaticalInformation

home to the Malaiyaha (Indian) Tamils.[148] While the Ministry of Health does disaggregate data by sex, it does not routinely report sex disaggregated health statistics. Other axes of difference like gender, sexual orientation and disability are completely obscured by a lack of data. In the absence of such data, it is impossible to delve into health inequities meaningfully.

## 13. Conclusion

The Government of Sri Lanka (GOSL), between 2018 and 2020, respected, protected and fulfilled the right to health by supporting the Free Health policy. Despite its limitations, the latter guarantees access to healthcare services on a non-fee levying basis, although the public system is weighed down by resource deficits at multiple levels, compelling even the poorest to incur out-of-pocket expenses in the private sector. Over the years, the growth of the private health sector has been aided by fiscal incentives, such as tax and import concessions, provided by the government as well as the latter's failure to invest adequately in the public healthcare system. These developments have widened inequities in access, amplified by a weak regulatory environment. For economically disadvantaged communities in rural areas, services are in short supply or simply unaffordable. The care needs of vulnerable groups like the elderly and people with disabilities remain unaddressed.

Health reform takes place with little participation of citizens. This also means that health policy making lacks transparency and accountability. Within the healthcare system, lengthy and ineffective mechanisms of redress make it near impossible for

148. "Annual Report of the Family Health Bureau 2019, "Family Health Bureau (2021). https://drive.google.com/file/d/1j3KdkBN0cwueRB9opmYsJN_03tNGvwDz/view

people to demand justice. More than a decade after the end of the civil war, ethnicity and language are unresolved concerns. Social class, gender and ethnicity intersect to structure healthcare experiences, for young people, women, LGBTIQA+ communities, people living with HIV/AIDS, and sex workers, resulting in health inequity. In 2020, the COVID-19 pandemic response was tainted by military incursion of the civil health sector as well as policies that discriminated against Muslim communities and other vulnerable groups, such as factory workers and prisoners. Even in other areas, the social and structural determinants of health have been largely neglected by the Government.

Applying a rights-based approach compels us to consider the availability, accessibility, acceptability and quality (3AQ) of health-related services, through a lens of equity and non-discrimination.[149] While this approach helpfully throws light on gaps and understudied areas in relation to GOSL's efforts to respect, protect and fulfil the right to health, it also raises a number of questions. For one, the right to health is not explicitly enshrined in the constitution of the country, although a Free Health policy guides the delivery of healthcare services in Sri Lanka. How do we understand redistributive policies like Free Health or Free Education in the absence of a constitutional guarantee to the right to health? Are collective claims on the state any less valid than mechanisms that allow individual citizens to resort to legal action on the right to health?

Second, and relatedly, how do we understand the individual right to health against collective entitlements to public health?

149. Gruskin et al., "'Rights-Based Approaches' to Health Policies and Programs: Articulations, Ambiguities, and Assessment," *Journal of Public Health Policy,* 31, no 2(2010): 129-145. https://doi.org/10.1057/jphp.2010.7

As Meier argues,[150] dwelling on individual health rights could obscure the bigger picture or societal structuring and patterning of ill health, influenced by macro political and economic actors and forces, the latter being often neglected considerations in public health. The human rights establishment does not, for instance, grapple with the steady weakening of public health systems across the world and especially in the global South, under structural adjustment programmes and/or other interventions by the World Bank and International Monetary Fund (IMF).[151] Amidst the calls for "private sector engagement" for universal health coverage, even within the United Nations and its agencies, how does one understand the privatisation agenda that has underpinned health sector reform in the post-Cold War era, through a human rights lens?

Third, are governments to be held solely accountable to the right to health? What about intergovernmental entities and multilaterals that operate at the global level, for instance, the World Bank and International Monetary Fund, or philanthropic actors like the Bill and Melinda Gates Foundation, or multinational conglomerates, all of whom have considerable influence on global and national health policies and budgets?[152] How do we ensure that such actors also respect, protect and fulfil the right to health? And, lastly, to what extent do rights-based approaches create space for discussions on ongoing coloniality in global health? These are some tensions that need to be resolved in tandem with health rights advocacy at the country level.

150. Benjamin Mason Meier, "Advancing Health Rights in a Globalized World: Responding to Globalization through a Collective Human Right to Public Health," *The Journal of Law, Medicine & Ethics* 35, no 4(2007): 545-555. https://doi.org/10.1111/j.1748-720X.2007.00179.x

151. M. Rodwan. Abouharb & David. Cingranelli, *Human Rights and Structural Adjustment* (Cambridge University Press, 2007).

152. Birn et al., Textbook of Global Health (Oxford University Press, 2017).

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