

# COUNTRY PROFILE

## ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS: SRI LANKA



Women and Media Collective  
Established 1984



# 1. Introduction

The total population of Sri Lanka for 2012 was 20,271,464 with 51.6% of the population being female (DCS, 2012). Sri Lanka is a multi-ethnic and multi-religious country. Almost 75% (74.9%) of the total population comprises of Sinhalese, while 11.2% are Sri Lanka Tamils, 9.3% are Sri Lanka Moors, 4.1% are Indian Tamils and 0.5% comprise of other ethnic groups (DCS, 2012). In terms of religion, 70.1% are Buddhists, 12.6% are Hindus, 9.7% are Islam, 6.2% are Roman Catholics and 1.4% comprise of other Christians (DCS, 2012). The life expectancy at birth for females was 77.9 years while it was 70.3 years for males. Literacy rates for females were at 92.6 in 2014 whereas it was slightly higher at 94.2 for men (LFS, 2014). Net school enrolment rates were however, higher for females at school and college levels. Although education data indicates that women are at an advantage, employment data indicate that there are significantly lesser proportions of females in the workforce. National data from 2014 indicate that only 34.7% females (15 years and over) were economically active whereas it was 74.6% for males (LFS, 2014). For the population over 20, female labour force participation was 37.3% for females and 81.2% for males (LFS, 2014). Female departure for foreign employment has declined from a range of 75% to 62% during the period from 1993 to 2004 to 49.07% in 2012, although the number of departures has been increasing gradually reaching 138, 547 in 2012. 86% of these women migrated for employment as housemaids (SLBFE, 2012). Sri Lanka's Human Development Index (HDI) value for 2013 was 0.750, positioning it at 73 out of 187 countries. This rate is above the average of 0.735 for countries in the high human development group and above the average of 0.588 for countries in South Asia (UNDP, 2014).

This brief socio-economic and demographic background of Sri Lanka helps give context to the information presented in this country profile. It will first look at the current definitions of sexual and reproductive health (SRH) and sexual and reproductive rights (SRR). It will then present a brief introduction to the SRH and SRR context of Sri Lanka prior to a detailed look at some of the national policy and legislative frameworks in place to address key areas of sexual and reproductive health and rights. It will also briefly present some key recommendations to address identified gaps and issues in ensuring universal access to SRR in Sri Lanka.

According to the Programme of Action of the International Conference on Population and Development (ICPD), the right to reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Accordingly, men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (UNFPA, 1994). The range of rights that ensure SRR are similarly written out in international conventions and through national legislation and policies at a local level.

The working definition of the World Health Organisation (WHO) notes that sexual rights uphold human rights as stated in national laws, international human rights documents and other consensus documents and include rights of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; access to and availability of information on sexuality, sexuality education; respect for bodily integrity; choice of partner; sexual activity; consensual sexual relations and marriage; decision to have/not to have children; and pursue a satisfying, safe and pleasurable sexual life. Further, reproductive rights are human rights, similarly recognised, that gives the opportunity for couples and individuals to have the desired number of children when they want to, access to adequate information and means to do so, and the right to attain the highest standard of SRH. It encompasses making reproduction decisions free of discrimination, coercion and violence, as expressed in human rights documents (Thanenthiran et al, 2013).

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## 2. The sexual and reproductive rights status in Sri Lanka

In Sri Lanka, sexual and reproductive health rights and services are prioritized mainly around maternal and child health and family planning. While the median age at first marriage has declined from around 25 years to 23.3 years, the Total Fertility Rate has increased from 2.1 to 2.13 (SLDHS, 2009). These changing trends have implications for service provision. According to the Family Health Bureau, 64.6% of the eligible families registered under care of the Public Health Midwife (PHM) had been using any method of contraception at the end of 2012. The proportion using modern and traditional methods were 55.4% and 9.5% respectively, while 35.1% did not use any form of contraception (FHB, 2014). Sri Lanka's Maternal Mortality Rate (MMR) stands at 32.5 maternal deaths per 100,000 live births (FHB, 2014). Every maternal death in Sri Lanka is investigated through the Maternal Death Surveillance and Response (MDSR) system that includes a Maternal Death Audit. Sri Lanka is currently targeting zero preventable maternal mortality. Further, data from 2013 indicates that 99.9% of all births were institutional deliveries and only 0.1% of all deliveries were conducted by untrained personnel (FHB, 2014). Sri Lanka is classified as a country with a low prevalence level of the HIV/AIDS epidemic in the South Asia region with an estimate of 3,000 (2,000 – 5,000) people living with HIV and an estimated prevalence rate of less than 0.1% (adults 15-49 years) as at 2014 (NSACP, 2014). Sri Lanka has signed and ratified many international conventions that attempt to address the empowerment of women, combat gender-based violence, improve the health and wellbeing of women and girls and ensure gender equality. Some of these documents include: the International Conference on Population and Development Programme of Action (Adopted in 1994); the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (Ratification in 1981) and its Optional Protocol (Accession in 2002); the International Covenant on Civil and Political Rights (Accession in 1980); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (ratification in 1994); the Vienna Declaration on the Elimination of Violence Against Women; the Millennium Declaration; the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Accession in 1996); and more recently the Sustainable Development Goals (2015). The extent to which these are enforced

or addressed through national law, policy and programmes in an effective manner is, however, debatable as signing the international covenant does not automatically make it binding unless a law is formulated based on it.

At a domestic level, Sri Lanka has addressed SRR through several policies and legislation that will be looked at in detail in this profile. It must be noted that sexual and reproductive rights in Sri Lanka mostly focus on maternal and child health and family planning. Gender-based violence (GBV) is addressed through various legislation, policies and programmes, while HIV/AIDS is addressed through policies that address non-discriminatory practices in the work place. Areas with little to no progress in recent times are those pertaining to sexual orientation, gender identity and gender expression. Comprehensive sexuality education for adolescents and youth is a priority area that needs attention. Therefore, while considerable progress has been made in line with international conventions, there is still much to be done especially in terms of rights and services for vulnerable sub-populations of women (young girls from rural backgrounds, widows, sex workers, female headed households, single, unmarried women, lesbian, gay, bi-sexual and transgender persons). There is also much to be done in economically lagging districts and those in the conflict-affected areas.

### Policies on Sexual and Reproductive Health

According to the World Health Organisation (WHO), national policies and strategies are part of a process that tries to align country priorities with the real health needs of the population and make better use of all available resources for health. Therefore, in order for quality SRH services to be universally accessible and available, they must be prioritised through national policies. Sri Lanka however, does not have one single policy document that addresses SRH but has several policies that separately address components of SRH. While the available policies are discussed in the respective sections of this profile, the following are some of the key policies:

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- Population and Reproductive Health Policy (1998)**  
This policy addresses fertility, safe motherhood, gender equality, adolescent and youth behaviour, services for the elderly, migration and urbanization, public awareness of population and reproductive health issues, population planning and the collection of quality population and reproductive health statistics.
- National Policy on Maternal and Child Health (1992, 1996, 2008, 2012)**  
This policy addresses maternal, new-born, infant and child care, pre pregnancy care, care of older children and adolescents, and family planning integrated with other related health issues such as STD/HIV/AIDS, gender and women's health. However, it does not cover all aspects of reproductive health relating to the reproductive system.
- National Strategic Plan on Maternal and New-born Health (2012-2016)**  
The guiding principles of this plan currently being implemented, articulate the need to be culturally sensitive and responsive, respect human rights and be gender sensitive. The need for men to assume a greater role and responsibility for the health of the mother and new-born is also stated. However, there is no specific reference to sexual orientation or gender identity within the gender sphere. It also articulates the need to ensure equitable service provision to all those who are internally displaced, marginalised, and vulnerable, and in post-conflict situations.
- The Family Policy of Sri Lanka (2011)**  
This policy includes the elimination of violence against women as well as the neglect and abuse of children. It also discusses the protection of female headed households, health and welfare of families with disabled persons, pregnant women, adolescents and youth, and also discusses the legal framework pertaining to family including the law on marriage and divorce.
- The National HIV/AIDS Policy 2011 and the National Strategic Plan 2013-2017**  
The policy articulates that the Government of Sri Lanka will ensure that the human rights of people living with HIV (PLHIV) are promoted, protected and respected; and that measures will be taken to eliminate discrimination and combat stigma to create an enabling environment to seek relevant services. The strategies discuss accelerating HIV prevention, care, treatment services and programme management and monitoring.
- National Health Development Plan (2013-2017)**  
In addition to maternal and child health and HIV/AIDS, this plan also discusses the promotion of reproductive health of men and women assuring gender equity and equality throughout the life course. It refers to providing access to sexual health services for sex workers, Men who have Sex with Men (MSM), beach boys, prisoners, migrant workers and those in the armed forces. Empowerment of adolescents to make informed choices regarding their SRH and introducing client- friendly reproductive health services are also noteworthy aspects of this plan.

## Difference between Median Age at Marriage and Legal Minimum Age at Marriage

The purpose of understanding the difference between median age at marriage and legal minimum age at marriage is to examine the extent to which the legal age at marriage is adhered to (ARROW, 2013). Whilst the legal age of marriage in Sri Lanka is 18 years of age for both males and females, the age of discretion (consent) is 16 years for females. Although the median age at marriage is 23.3 years for females, 14% of girls marry before reaching 18 years of age (SLDHS, 2009). Sri Lanka also notes variations in the median age at marriage when considering district data level on education and household economic status. It must be noted that during the conflict years, early marriage was adopted as a mechanism to safeguard girls and boys against conscription by the Liberation Tigers of Tamil Eelam (LTTE) terrorists (Goonesekere and Amarasuriya, 2013). Early marriage continues to happen in the North Central Province and the estate / plantation sector.

As Sri Lanka is a multi-ethnic and multi-religious country, legislation relating to marriage consists of the general law, customary law and personal law. Tamils are governed by the general law in most marriage-related matters, and the Law of Thesawalamai is applicable to those from Jaffna and the Northern Province. Kandyan Sinhalese can choose to be governed by the general law or customary laws. Muslims are governed by Muslim personal law. As such, it must be noted that the Muslim Marriage and Divorce Act of 1951 governs the 7% of Sri Lanka's Muslim population and does not specify a minimum age of marriage. The present Muslim law only requires the Quazi (judge of a Muslim personal law court), to give his consent to the marriage of a girl under 12 years of age (Marsoof, 2006). An effort to change the law for Muslims in 1995, when a minimum age of 18 years was set for all communities, was not successful. The criminal law makes sexual intercourse with a child bride below 16 years of age punishable as rape, but it has never been implemented to prosecute a male Muslim. Respect for religious ideology has been used as an argument to resist changes to the law permitting early marriage (UNESCAP, 2012). Considering the above discrepancies, it is important to make same the age of marriage and the age of consent, and do so across all communities of the country. Early marriage before the girl child is sufficiently mature physically, sexually and psychosocially, risks her health and that of the baby and is associated with higher morbidity and mortality for both. This is a valid reason to harmonise general law and Muslim personal law to the advantage of Muslim girls and the whole Muslim community.

## Policies on HIV and AIDS

The principle of non-discrimination enshrined in the Universal Declaration of Human Rights and other human rights instruments prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, property, birth or other status. In 1996, the UN Commission on Human Rights resolved that the term 'or other status' used in several human rights instruments 'should be interpreted to include health status, including HIV/ AIDS', and that discrimination on the basis of actual or presumed HIV status is prohibited by existing human rights standards. The ICPD Programme of Action further called for non-discrimination towards people living with HIV (ARROW, 2013).

Although HIV/AIDS prevalence in adults is less than 0.1% in Sri Lanka, it is important to note whether the government has put in place policies to uphold non-discrimination on the basis of HIV status. In this regard, the country has developed a key policy that addresses HIV/AIDS indicating a responsible approach to ensure the prevention of an epidemic in the long run. The National HIV/AIDS Policy of Sri Lanka (2011) addresses non-discrimination of people living with HIV (PLHIV) in health and education sectors and in reproductive and family life. For employment, the National Policy on HIV and AIDS in the World of Work in Sri Lanka (2010), prohibits discrimination against people based on real or perceived HIV status for purposes of recruitment or at any other stage of employment as well as retention in employment based on being medically fit to work. The policy identifies female sex workers and their clients, men who have sex with men and injecting drug users as vulnerable persons.

**Prevention interventions will be focused on highly vulnerable groups and also the general population with special attention given to in and out of school youth through the involvement of health and non-health sectors such as, and that shall not be limited to, education, labour, tourism, foreign employment, plantations, armed forces and police. In the implementation of preventive measures the role of political and religious leaders, governmental and non-governmental sectors, international organizations, media and other relevant stake holders will be recognized.**

*National HIV/AIDS Policy of Sri Lanka (2011)*

The National HIV Strategic Plan Sri Lanka (2013-2017), is also being implemented by all sectors of government and civil society, under the technical guidance of the National STD/AIDS Control Programme (NSACP) with high level leadership from the National AIDS Committee (NAC). It also includes the need to minimize HIV related stigmatization and discrimination; and promote gender equality, human rights and health equity. The Strategic Plan is supported by a National HIV Monitoring and Evaluation Plan - Sri Lanka 2013-2017 and budget.

## Policies on Adolescent Sexual and Reproductive Health Services

The rights of adolescents to appropriate services to meet their SRH needs were acknowledged in a special section on adolescents in the ICPD Programme of Action. Countries were called upon to protect and promote the rights of adolescents to reproductive health education, information and care (ARROW, 2013). This section looks at whether Sri Lanka has acted on this recommendation, and the barriers that adolescents continue to face in accessing SRH services.

Adolescents (10-19 years) comprise of 19% of the total Sri Lankan population and of them 70% attend schools (FHB, 2013). At present various government and non-governmental organizations provide numerous services to adolescents but there appears to be a lack of cohesion in response. The School and Adolescent Health Unit of the Family Health Bureau, acts as the focal point for the National School and Adolescent Health (SAH) Program in the Ministry of Health. This unit works in close collaboration with the Ministry of Education and is responsible for planning, monitoring and evaluation of the program in the country (FHB, 2013). At present the school health programme focuses on five major thematic areas including: 1) School Medical Services; 2) Maintenance of Healthy School Environment; 3) Life Skills based Health Education; 4) School Community Participation; and 5) Healthy School Policies (MOH, 2014). Reproductive health education thus falls under the third thematic area. However, various studies show that the knowledge among adolescents on their SRH is poor (UNICEF, 2004). Such a lack of knowledge on SRH can be a factor that leads to teenage pregnancy. In Sri Lanka, 5.3% of registered pregnant mothers are teenagers (FHB, 2014).

Sri Lanka recently released the National Youth Policy (2014) which notes the lack of information and access to youth friendly services on SRH as a key issue faced by youth and also acknowledges the need for sexual and reproductive health education at school level, and in higher education sectors including universities and technical and vocational training institutes. It highlights the importance of implementing the National Policy and Strategy on Health of Young Persons (2011) and the National Strategic Plan on Adolescent Health from 2013 – 2017 (2013). In terms of health services for adolescents, the National Policy and Strategy notes a package of services including: 1) Medical Screening, 2) Nutritional Assessment, Counselling and Supplementation, 3) Contraceptive services for eligible young persons, 4) Clinical Management of reproductive health problems 5) Syndromic Management of STIs (FHB, 2013). Measuring the level of implementation and progress subsequent to the development of the policy is yet to be determined due to the recency of the policy.

Adolescents who drop out of schools are at a higher risk because they are deprived of these educational and service inputs. The Public Health Midwife (PHM) and the Public Health Inspector (PHI) are responsible for providing care for out of school adolescents (FHB, 2013). These services, especially maternal health services are required to be provided to eligible couples irrespective of marital status. In 2011 the Ministry of Health requested and was granted clearance by the Attorney General's Department for PHMs to provide contraceptive services to teenagers less than 16 years of age if they were in consensual union with a partner without fear of arrest by the police. The decision was conveyed to the Inspector General of Police such that police would be instructed and apprised of the Attorney General's decision.

## Grounds under which abortion is legal

In the present context, 'abortion' refers to 'induced' abortion, which is the intentional termination of a pregnancy before the foetus can live independently. An abortion may be elective (based on a woman's personal choice) or therapeutic (to preserve the health or save the life of a pregnant woman). In most countries of the world, induced abortion is regulated by law which spells out the circumstances under which a woman approaching a health facility to have a pregnancy terminated may be legally provided abortion services according to the laws of the land (ARROW, 2013).

In Sri Lanka, abortion is considered a criminal offence as stipulated in the Penal Code unless the pregnancy puts the woman's life at risk. Estimates suggest that around 600 to 700 abortions are carried out daily in the country (UNFPA, 2009). While exact and reliable statistics are not available, the Ministry of Health assumes that a majority of abortions are unsafe as they are performed as illegal procedures, under septic conditions, and by poorly qualified persons. This assumption is supported by the fact that according to the Ministry of Health nearly 12% of maternal deaths in Sri Lanka are due to septic abortions- the second most common cause of direct maternal deaths (Arambepola and Rajapaksa, 2014). Sri Lanka also shows higher abortion rates among married women of mid child bearing years, highest among the 35-39 aged group (Arambepola and Rajapaksa, 2014). However, the approach adopted to deal with abortion related issues by the Ministry of Health is through minimising unwanted or unplanned pregnancies.

**Whoever voluntarily causes a woman with a child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished imprisonment of either description for a term which may extend to seven years, and shall also be liable to a fine.**

*Section 303, Penal Code of Sri Lanka, 1833*

In 1995, the Ministry of Justice presented the Penal Code Amendment Bill to Parliament in which Clause 3 provided for the relaxation of the strict prohibition on the termination of a pregnancy and sought to decriminalize termination in the case of rape and incest and congenital abnormalities incompatible with life. However, in presenting

the Bill in Parliament Clause 3 was withdrawn by the then Minister of Justice and was not voted on. The amendment to Section 306 was therefore not passed (Law Commission of Sri Lanka, 2013). Such amendments and attempts to change the law on abortion even under specialised circumstances are often restricted due to religious and cultural pressures (Balachandran, 2009). This factor also makes it a politically sensitive issue and more advocacy is required to address it in a meaningful way.

## Gender-based violence (GBV)

Sri Lanka continues to experience a high incidence of violence against women, whether it is domestic violence, sexual harassment, incest, rape or sexual abuse as evidenced by police statistics, media reports, documentation and research carried out by both government and non-governmental agencies (Wijesekera et al, 2014). These issues receive attention from diverse sectors, the State, non-government sector and civil society, which address preventive measures and provide redress for victims. Despite this attention, violence against women continues to take place in the private and public sphere and the measures taken to prevent and redress, remain insufficient (Jayasundera, 2009). This section will first look at the prevalence of GBV and then explore the legislative mechanisms in place to prevent and address GBV.

### Extent of Gender-based violence

Timely and verifiable data on the extent and prevalence of gender based violence in Sri Lanka is scarce. However, data from various sources indicate that there is a relatively high incidence of GBV. The following section has been compiled through various studies conducted in the past on the relevant topics. While this data cannot be confidently generalised to the current context of the whole of Sri Lanka (due to varied nature of time, locations, sample sizes, context, measurements etc. of the studies), it presents a picture that helps understand the extent to which GBV is present.

- **Rape and grave sexual violence:**

According to 2003 police records, the majority (78%) of victims of grave sexual abuse (seduction, rape, incest and procreation) were girls, especially younger girls under 16 years of age (SLMA, 2011). During the period 2007 and 2013 complaints were filed in only about 20-25% of reported rape cases (Wijesekera et al, 2014). Recent research has found that only 3.2% of those who admitted to committing

rape had been arrested, and only 2.2% had been jailed. In other words, in 96.5% of rape cases, the rapist had experienced no legal consequences (Wijesekera et al, 2014). In a six country study that surveyed in the Asia Pacific region on the meaning and causes of men's violence against women, the figures for non-conviction were the worst in Sri Lanka (Fulu et al, 2013). The study found that the motivation in the vast majority of cases was a sense of sexual entitlement among the men. The study also revealed that the level of impunity — from families, communities and the law — for sexual violence including rape is quite high, with only 18% of men who had perpetrated forced sexual relations reporting as being afraid of being found out. Significantly, only 7% of perpetrators had experienced legal consequences such as being arrested with charges dropped, or arrested and resulting in a court case or jailed (De Mel et al, 2013).

- **Domestic violence and intimate partner violence:**

Domestic and intimate partner violence is one of the most pervasive forms of violence against women in Sri Lanka. Women irrespective of their class, caste, religion, ethnicity and geographic location are vulnerable to such violence. Statistics of domestic violence compiled by the Children and Women's Bureau Desks of police stations as well as women's organisations give an indication of the seriousness of the problem: Organisations providing services to victims of domestic violence noted that in 2009, 12,000 complaints were received, and the Children and Women's Desks at police stations recorded a total number of 94,094 'family disputes' (Kodikara and Piyadasa, 2012). In order to understand the data on the topic (underreporting, rates of prevalence, numbers of cases filed, assistance sought etc.) it is also important to look into the reasons for women to stay in abusive relationships. Intimate partner violence during pregnancy is also a serious concern in Sri Lanka with serious consequences such as miscarriages, preterm labour, depression, homicide and death (Senanayake, 2011). While studies have found that cultural conditioning and socialization processes contribute to such situations, other studies also found that illiteracy, unemployment and the consequent dependency on their husbands/partners for existence appear to be additional factors. Most women however, continue in abusive relationships for the welfare of their children (WHO, 2008). Understanding such causes will

better enable the tailoring of support services for these victims.

- **Sexual harassment:** Studied conducted on sexual harassment note that there is a high incidence of street-based sexual harassment that is a virtually unreported crime, condoned and invisibilised which occurs with rampant impunity. It also notes that sexual harassment in the workplace is equally insidious and brings into play unequal patriarchal power relations that are not dealt with in any seriousness either in the public sector or in the private sector (Wijesekera et al, 2014). While national level data is scarce under this topic as well, a study conducted in 2004 noted that as much as 94% of school girls, girls in higher education institutions and working women had experienced sexual harassment in public transport (UNFPA, 2012). Further, 62.3% women in wholesale and retail industry, educational sector and financial intermediary sector had experienced sexual harassment in the work place (UNFPA, 2012). An interesting factor also noted in Sri Lanka is that sexual harassment in Government Ministries and government departments is on the rise in rural as well as urban areas with the Ministry of Health receiving around 10 complaints a day of sexual harassment (Balachandran, 2012). It must also be noted here that the definition or considerations of sexual harassment also varies. As a study showed, unwanted attention, unwanted work demands, rumours or locker room talk, verbal comments, physical contacts and sexual propositions were considered as sexual harassment while sexist behaviours and gender harassment, which are universally identified as sexual harassment, were not thought so by Sri Lankan women (Adikaram et al, 2011).
- **Violence against lesbian, gay, bisexual, transgender and intersex people:** Due to an out-dated British colonial law that criminalises homosexuality in Sri Lanka, very few studies have focused on violence and discrimination faced by LGBTI People living in Sri Lanka. One study conducted found that over half of the Lesbian Bisexual and Transgendered (LBT) people who participated in the study reported sexual violence, ranging from sexual harassment to intimate partner violence and rape where perpetrators were employers, colleagues, family members and strangers. They also suffered long lasting effects of the violence, including depression,



anxiety, persistent anger, chronic illnesses, and addictions (WSG, 2014). Attempting suicide was a coping mechanism for a significant number of those who had experienced violence and discrimination (WSG, 2014). These individuals who are the victims cannot report crimes to the police without fear that their sexual orientation or gender identity will be exposed or highlighted, leading to further discrimination and marginalization and, potentially, to prosecution (See section on Sexual Orientation and Identities below). For the same reason, although Sri Lankan law provides significant protection to people who have been fired from their jobs or displaced from their housing, victims of discrimination in employment or housing on grounds of their sexual orientation or gender identity cannot avail themselves of these protections without risking further violations of their rights (Equal Ground, 2013).

- **Gender based violence through harmful traditional practices:** Sri Lanka has a relatively low prevalence of harmful traditional practices in relation to GBV in the Asian region. A study done on traditional practices that particularly affect women and girls noted some practices that are harmful to women. These practices are still prevalent in a decreasing trend in Sri Lanka and needs public awareness on its harmful effects on women in order for these to be eradicated. As per this UNESCAP study (2012):
  - The ‘virginity test’ (showing of blood by a bride upon the first act of intercourse as proof of her virginity) is practiced among Sinhalese. It is assumed that the increased mobility, education and employment opportunities for women and promotion of women’s rights will contribute to the erosion of this practice that is degrading and discriminatory. There is little evidence to show that this is practiced among other communities such as Tamil, Hindu and Muslim communities;
  - Female circumcision is a very closely guarded social practice, considered a private family matter within the Muslim community;
  - In Tamil and Hindu communities, menstruating women are not allowed to enter places of worship;
  - Induced abortion using traditional abortifacients such as inserting twigs into the cervix or drinking traditional toxic potions, which are known to cause intense vomiting and abortion seem to be used

less often than before. It is a practice mostly by low-income women mainly when a family is unable to provide for another child, when contraceptives fail, due to social stigma arising from single parent status, pregnancy of a widow or the shame associated with the birth of a baby when the eldest child in a family was well into adulthood.

### Legislation related to gender-based violence

The Government of Sri Lanka has the primary responsibility to prevent and respond to sexual and gender based violence including taking all necessary legislative, administrative, judicial and other measures to prevent, investigate and punish acts of GBV and provide adequate care, treatment and support to victims. Sri Lanka has enacted several national laws and procedures in order to criminalize some acts of sexual violence and gender-based violence. These are presented on **Table 1**.

Sri Lanka has developed a Women’s Charter (1993) which is the main policy statement by the government, regarding the rights of women. It expresses the state’s commitment to remove all forms of discrimination against women, achieve gender equality and address crucial areas relevant to women. It establishes standards in seven broad areas: political and civil rights, rights within the family, the right to education and training, the right to economic activity and benefits, the right to health care and nutrition, the right to protection from social discrimination and the right to protection from gender-based violence. The Charter as enabled the setting up of a National Committee on Women. Unfortunately, however, neither the Women’s Charter nor the National Committee on Women has legislative power. The National Action Plans on Women developed periodically since 1996 are still not integrated with the development plans of other key ministries, indicating the gender based attitudes of successive governments towards women and the failure to recognise them as partners in sustainable development.

Table 1: Legislation on Gender Based Violence in Sri Lanka

Topic	Legislation	Description
Intimate partner violence	Prevention of Domestic Violence Act No. 34 of 2005	Addresses physical, verbal, sexual and psychological abuse. Economic deprivation and damage to property can also be applied. The person affected by the violence can also obtain a Protection Order. The Plan of Action for the implementation of this Act is pending at the Ministry of Women's Affairs at present.
	Penal Code Act No. 22 of 1995 (Amendment)	Can be applied to situations of violence (hurt, grievous hurt, grievous sexual abuse and offences against the human body) that take place within the domestic sphere or within intimate relationships.
Rape	Penal Code Act No. 22 of 1995 Section 363 (Amendment)	Legislature is applicable only where a man has sexual intercourse with a woman without her consent. Also applicable for consensual intercourse with a woman of unsound mind.
	Penal Code Act No. 22 of 1995 Section 363 (e) (Amendment)	Legislature for statutory rape in cases where the girl is below the age of 16, sexual intercourse with consent also constitutes rape where proof of the act of intercourse alone is sufficient to prove rape. (Exception of married Muslims)
	Penal Code Act No. 22 of 1995 Section 364 (2) (a) (Amendment)	Legislature related to custodial rape is applicable when a public officer or person in a position of authority takes advantage of that position and commits rape.
	Penal Code Act No. 22 of 1995 Section 364A (Amendment)	Legislature related to incest where there is sexual intercourse between direct descendants, sibling (full blood, half blood or adoptive), and adoptive parent, grandparent etc.
		Marital rape is not criminalised unless the wife and husband are judicially separated. The Government tried to include marital rape in the 1995 amendments, but received opposition from Muslim and Catholic lobbies (Hussein, 2001).
Sexual Abuse	Penal Code Act No. 22 of 1995 Section 365B (Amendment)	Legislature on grave sexual abuse covers aspects that do not come within the definition of rape.
		Female Genital Mutilation is not covered under a separate law.
Sexual harassment	Penal Code Act No. 22 of 1995 Section 345 (Amendment)	Includes the use of words and actions by persons in authority (eg. Police, armed service personnel, school officials, medical officials etc.) and unwelcome sexual advances in the work place. This can also be applicable to cover misuse of internet and emails that are obscene or make allegations of a sexual nature in order to harass, intimidate or embarrass.
	Bribery Act of 1954 Bribery Act of 1980	Unsolicited sexual propositions in the workplace which are linked to benefits and career advancement, or further harassment, dismissal, etc. are applicable here.
	Disciplinary Inquiries contained in the Staff Collective Agreement of 1997 Section 18	Could be interpreted to provide space to address sexual harassment to all clerical staff.
	Disciplinary Action in the Labour Collective Agreement of 1998 Section 18	Could be interpreted to provide space to address sexual harassment to all estate/plantation sector workers.
Other	Prohibition of Ragging and Other Forms of Violence in Educational Institutions Act No. 20 of 1998	Specific to universities and educational institutions. Addresses sexual harassment.

Source: Various legislation as noted.

## Legislation and policies on sexual orientation

Sexual orientation covers sexual desires, feelings, practices and identification. Sexual orientation can be towards people of the same or different sexes: same-sex, heterosexual or bisexual orientation (ARROW, 2013). Legislation on sexual orientation may relate to aspects such as marriage, adoption, discrimination and even hate crime.

Same-sex relationships are criminalised in Sri Lanka. Under Section 365A (See Box) of the country's Penal Code, same-sex relations are punishable by a jail term of up to ten years. Prior to 1995 this law was only applicable to men and was amended in 1995 to be gender-neutral. The law refers to "gross indecency" without specifying what amounts to it, leaving it open to the interpretation of law enforcement personnel. While there have been no convictions under this law in the past 50 years, these laws are used to persecute individuals on grounds of their real or perceived sexual orientation and gender identity and expression (Equal Ground, 2013).

**Any person who, in public or private, commits, or is a party to the commission of, or procures or attempts procure the commission by any person of, any act of gross indecency with another person, shall be guilty of an offense, and shall be punished with imprisonment of either description, for a term which may extend to two years or with fine or with both and where the offence is committed by a person over eighteen years of age in respect of any person under sixteen years of age shall be punished with rigorous imprisonment for a term no less than ten years and not exceeding twenty years**

**and with fine shall also be ordered to pay compensation of an amount determined by court to the person in respect of whom the offence was committed for the injuries caused to such person.**

*Section 365A*

*Penal Code of Sri Lanka, 1995*

Chapter 3 of the Constitution of Sri Lanka notes that it is a fundamental right of citizens to not be discriminated against on the grounds sex and not gender. Further, there are no specific policies of non-discrimination in employment, marriage and adoption of children for same-sex couples. Although some private workplaces include non-discrimination policies, these policies seldom cover discrimination on the grounds of sexual orientation and gender identity.

## Legislation and policies on gender identities

Gender identity refers to the complex relationship between sex and gender, referring to a person's experience of self-expression in relation to social categories of masculinity or femininity (gender) as a person's subjectively felt gender identity may be at variance with their sex or physiological characteristics (ARROW, 2013). The terms 'transpeople' or 'gender-variant' people include those with a gender identity that is different from the gender they were assigned at birth, and those who wish to portray their gender in a way that differs from the gender they were assigned at birth. These include, among many others, transsexual and transgender people, transvestites, cross-dressers, as well as intersex people who relate to or identify as any of the above (Balzer et al, 2012 as quoted in ARROW, 2013).

In Sri Lanka, persons with varied gender identities can be criminalised under the Penal Code reference to "cheat by personation" (See Box) and the Vagrancy Ordinance of 1842. The Vagrancy Ordinance is arbitrarily and wrongfully used by the police who have the power to determine and interpret the law; they detain transgender people, and people of sexual minorities because they appear to look different (WSG, 2011).

**A person is said to “cheat by personation” if he cheats by pretending to be some other person or by knowingly substituting one person for another, or representing that he or any other person is a person other than he or such other person.**

*Section 399, Penal Code of Sri Lanka, 1833*

As the existence of transgendered persons in Sri Lankan society is not taken into consideration in designing healthcare, there is a lack of information on services such as sex reassignment operations by public health providers. Limited procedures however are available but the full process requires seeking services overseas. There is a general lack of awareness regarding the potential health needs of transgender persons on the side of healthcare providers, and in particular on the provision of reproductive and sexual health care which is designed without taking their specific needs into consideration. There have also been cases in which families seek assistance from mental healthcare providers to ‘cure’ persons who manifest ‘non-normative tendencies’ resulting in forced institutionalization, forced psychotherapy, forced medication and even forced confinement. Further, criminalisation renders lesbian, bisexual and transgender women and men vulnerable to a range of other violations of their human rights to health. There have also been instances where transgender persons have been denied employment due to their sexual identity (WSG, 2011).

## Grievance redress mechanisms for sexual and reproductive health services

In a human rights framework, accountability combines elements of responsiveness, answerability and redress. Therefore, it is important to assess government accountability in ensuring SRH services by examining whether there are mechanisms for grievance redress when users have complaints related to the availability, access, affordability, acceptability or quality of SRH services (ARROW, 2013).

In Sri Lanka, services users are largely unaware

that they are entitled to complain if dissatisfied with services. Most government mechanisms lack a formal complaint/redress mechanism and if available it is not widely known. Receiving health care at no cost also makes it difficult to complain. However, there are various mechanisms in place to address aspects of grievances for SRHR that can be addressed through the wider agenda of women’s rights. Some such mechanisms include, but are not limited to the following:

- National Committee for Women (NCW) works with a mandate to monitor and ensure the implementation of provisions as stated in the Women’s Charter (briefly described above) through policy formulation, awareness raising and advocacy.
- The Center for Gender Based Complaints run by the NCW and functions under the purview of the Ministry of Women’s Affairs and receives complaints on gender-based discrimination.
- Hospital Health Desks- Mithuru Piyasa help centres are located in several general hospitals in selected districts. These provide medical and advisory services for women and under-aged children who are subjected to sexual abuse.
- Women’s shelters are available throughout the country and are run by government institutions (although government involvement is considerably less), NGOs, charities, and faith-based organisations. These can be used by women victims of violence and their children.
- Counselling Centres of the Ministry of Women’s Affairs are available in several districts and provide services for victims of violence.
- The Legal Aid Commission (LAC) of Sri Lanka provides legal assistance to vulnerable groups including women, children, migrant workers, prisoners and the elderly through its 65 centres across the country. Developmental Legal Aid Desks at these centres provide legal counselling and legal representation in court cases. However, the LAC does not provide support for female sex workers.

### 3. Recommendations

Sri Lanka has made considerable advancements in health service provision as evidenced through the many positive indicators discussed in this Profile. The following recommendations are made to State actors and other stakeholders to enable them to address existing disparities and ensure universal access to Sexual and Reproductive Health (SRH) services.

- There is an urgent need to expedite process the of giving **legal status** to the Women's Charter and ensuring that sexual and reproductive rights, legislation and programming is included in its mandate.
- **Legislative reform** on abortion, marital rape, sexual orientation and gender identity and aspects of gender based violence is important. It is also important to decriminalise the abortion seeker and improve the quality of post abortion care and family planning services.
- The health policies currently in place need to be strengthened through the development of integrated and inclusive **SRH policies** that ensure availability of services without discrimination on the grounds of sex, gender, age, religion, race, marital status, sexual orientation, gender identity and other factors.
- Policies also need to underwrite the allocation of sufficient **human and financial resources** to implement and monitor current health policies and national strategic plans.
- It is pivotal to ensure that SRH policies and programmes are **universally accessible** to the whole population and in particular to those living in districts with poor health indicators such as the post conflict areas, estate sector and economically underperforming districts. SRH services and service access for the LGBT community is poor in comparison to heteronormative women and also needs strengthening.
- Although there is a well-established mechanism for data gathering for maternal and child health services, the absence of a single national level database is a critical drawback to effectively addressing SRH related issues including GBV. In order to support evidence based policy and programming, formal **data gathering systems** are required to collect, organise and analyse SRH related data.
- A **systematic public education** programme on human rights, including women's rights and sexual and reproductive rights as well as service availability and grievance mechanisms is needed. Such programmes will need to be simple, digestible and delivered with cultural sensitivity.

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## About Women and Media Collective

The Women and Media Collective (WMC) was formed in 1984 by a group of Sri Lankan feminists interested in exploring ideological and practical issues of concern to women in Sri Lanka. Since then WMC has been actively engaged in bringing about change based on feminist principles in creating a just society that does not discriminate based on gender. WMC has contributed at different moments in time to social and political change, the inclusion of women and gender concerns in the peace process, increased state recognition of women's rights, the enactment of new legislation or legislative and policy reform promoting and protecting women's rights, and recognition for the need to increase women's representation in politics. WMC has contributed to the formulation of the National Women's Charter, the National Action Plans for Women and the Migrant Rights Policy and co-ordinated the civil society organisations campaign which resulted in the enactment of the Domestic Violence Act of 2005. WMC has also engaged in policy discussions related to women's land rights, single women and female heads of households, peace-making and peace-building, and media reforms among others. WMC has also helped initiate women's networks and continue to work with a range of organizations from grassroots level local women's organizations to national level institutions, which have a direct voice in policy formulation and implementation.

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### About the Country Profile

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