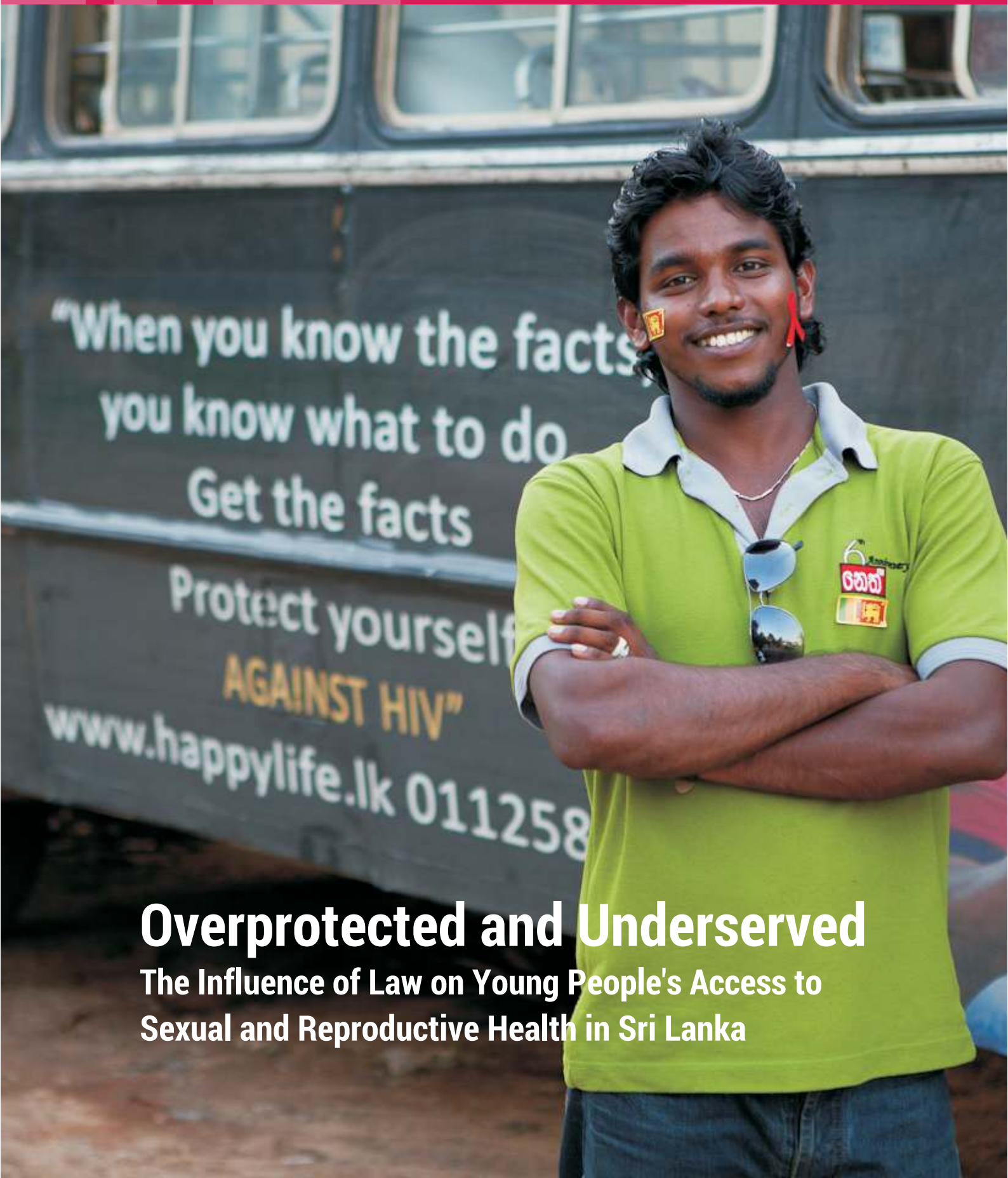
IPPF International Planned Parenthood Federation
South Asia Region

From choice, a world of possibilities



Overprotected and Underserved

The Influence of Law on Young People's Access to Sexual and Reproductive Health in Sri Lanka

Who We Are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals in more than 170 countries. IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Our Mission

To lead a locally-owned, globally connected civil society movement that provides and enables services and champions sexual and reproductive health and rights for all, especially the underserved.

Our Vision

All people are free to make choices about their sexuality and well-being, in a world without discrimination.

Acknowledgement

IPPF SARO would like to thank the team at the Coram Children's Legal Centre (CCLC) for implementing the research and writing the report.

This report was written by Kara Apland; with support from Elizabeth Yarrow, Jorun Arndt and Maurice Dunaiski at Coram International at the Coram Children's Legal Centre.

The methodology for this research draws and expands upon a pilot multi-country study conducted by Coram International and the International Planned Parenthood Federation in El Salvador, Senegal and the United Kingdom in 2012 - 2013.

IPPF SARO would also like to thank our Member Association in Sri Lanka; the Family Planning Association of Sri Lanka (FPASL) for their assistance and guidance throughout the study and for their feedback on earlier drafts of this report. In particular, we would like to thank Ms Thushara Agus, Mr Lasantha Gunarathne, Ms Madhusha Dissanayake and Ms Sumithra Tissera for their technical inputs and implementation of the survey tool and for providing information regarding specific legislation in Sri Lanka relating to rights based sexual and reproductive health service provision. IPPF SARO is very grateful to the team who coordinated the immense and diverse field work that was required for the study in multiple locations in Sri Lanka – Ms Thakshila Gamage, Ms Sujeeva Pathmini, Ms Udeshika Lumbini, Mr. S.K. Sunil Senarathne, Mr. Rajapakse Vithanage, Mr. Jeyan Ramadas, Mr. Yogeswaran Krishnan and Mr. Shahul Hameed Imthiyas. The authors would like to thank all the volunteers at the local FPASL chapters in Colombo and Batticalo as well as all the young people and service providers interviewed for this study.

Our thanks also to Ms Doortje Braeken at IPPF for her thought leadership and continued support of youth programming initiatives in the South Asia Region. At IPPF SARO, we would like to acknowledge the contribution of Mr. Manish Mitra as the technical lead for the research study. We are also grateful to Dr Jameel Zamir, Dr Ataur Rahman, Mr Ryan Joseph Figueiredo, Dr Abhijeet Pathak, Mr Deepesh Gupta and Ms Malavika Thirukode for their technical contributions and review of the study report. Lastly, our sincere gratitude to Ms Sangeeta Mathur and Mr Amit Malik for their help in coordinating logistics and financial management towards successful study implementation in Sri Lanka.

IPPF SARO gratefully acknowledges UNFPA Asia Pacific Regional Office who provided support for this independent study.

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Foreword

Asia is home to 850 million young people in the age range of 10-24 years. Although living in very diverse realities they all share similar challenges in the form of lack of information and meaningful participation in accessing services for their health and well-being.

Every country has specific laws that regulate access to SRH services for different age groups in different contexts. However, research on young people to date, covers their lived experience more often in the context of social, cultural and economic influences on their well-being. The influence of existing laws, it's absence and the gaps in its implementation have very rarely been explored.

In the recent past there have been a few seminal works relating to the study of country laws in the Asia – Pacific Region, the understanding of the law by young people and service providers and the law's everyday implementation. This includes the 'Overprotected and Underserved' series conducted in El Salvador, Senegal and the UK by IPPF in 2014.

These knowledge products detail existing legal principles and provisions. Pertinently, the mixed methods (reviews, quantitative and qualitative research) used in the studies above provide hitherto unexplored insights into the interplay between academic, legal, social and cultural beliefs and practices that together encourage or impede a young person's access to sexual and reproductive health services.

In line with these series in Europe, Africa and parts of the Asia Pacific, the International Planned Parenthood Federation – South Asia Regional Office (IPPF SARO) in partnership with UNFPA – Asia Pacific Regional Office (UNFPA APRO) embarked on creating an evidence base for countries in South Asia Region. IPPF SARO undertook these studies in India and Sri Lanka in 2015/2016.

Informed by the methodologies used previously, this report includes an introduction to current academic discourse on laws that regulate SRH service provision and the diverse lived experiences of young people and service providers. Young people living in rural and urban spaces, young adolescents from in-school and out-of-school settings, members from young key populations, young people living in post-conflict settings and service providers practicing in government and Member Association run service delivery points were interviewed and surveyed. Uniquely their knowledge, attitudes and practice on consent to medical treatment; privacy, confidentiality and reporting; age of sexual consent; criminalisation of same sex activity and gender based violence have been explored.

Overview of specific legal provisions pertaining to these thematic areas are provided below:

- Sri Lankan statutory law does not contain specific provisions in relation to young people's ability to consent to medical treatment (including to access SRH services).
- Sexual Reproductive Education in schools in Sri Lanka appears to be insufficient and inconsistent, often because teachers are resistant to teaching it (often due to pressure from parents). As a result, many young people who participated in the research were poorly informed about sexual and reproductive health.
- The lack of legal framework for sex reassignment surgery makes it effectively impossible for transgendered or intersex individuals to be legally recognised according to their gender identity and also limits their ability to access sex reassignment surgery.
- Lack of legal protection of confidentiality serves as an indirect barrier to access as young people don't feel their privacy will be protected, this increases the shame and embarrassment associated with accessing services.

The IPPF - UNFPA partnership in the South Asia Region aims to ensure continued investment by all stakeholders to better understand, train and implement services and programming for young people. Knowledge products such as the 'Overprotected and Underserved' series provide information that can be used to improve the versatility of a broad range of services such as Comprehensive Sexuality Education, Child Protection, Values Clarification and Attitude Transformation and Behaviour Change Communication. It provides a strong and current evidence base for advocacy and accountable collaboration among networks, organisations and individuals working with young people in the region.

Importantly, we are confident that these initiatives provide voice to young people and their collective wisdom in ensuring that they experience happy, healthy, safe and fulfilling sexual and reproductive health and wellbeing.

Anjali Sen
Regional Director
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Executive Summary

This study was designed to fill an important gap in research in Sri Lanka. Whilst existing research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, as well as knowledge and perceptions of law, on access to services. The research included a desk-based review of existing laws, regulations and policies on SRH in Sri Lanka, as well as the collection and analysis of qualitative and quantitative data from young people, parents and SRH service providers in Sri Lanka.

Laws that regulate access to services

Consent to medical treatment

Sri Lankan statutory law does not contain specific provisions in relation to young people's ability to consent to medical treatment, including to access SRH services such as contraception, STI testing and treatment, counselling, etc. However a general circular no. 01-25/2015 issued by the Ministry of Health and Indigenous Medicine provides that Adolescent Sexual and Reproductive Health (ASRH) services may be provided to a minor under the age of majority (18) irrespective of parental consent, if it is likely that the minor will engage in sexual intercourse which will be 'detrimental' to their physical or mental health without the provision of the service.

Service providers interviewed for the qualitative research generally expressed the view that children and young people have the right to access SRH services and that there is no legal or policy barrier to the provision of services to these groups, though a majority of service providers surveyed for the study stated that they are only legally able to provide access to SRH services to a minor after conducting an assessment of the young person's capacity. By contrast, most young people included in the study believed that there are legal restrictions on minors' access to SRH services. When asked why they thought a person had to be 18 to access SRH services without restrictions, however, young people tended to justify this view in terms of social and cultural norms rather than direct legal barriers.

Abortion

Section 303 of the Penal Code establishes that 'causing a woman to miscarry' is illegal and subject to up to 7 years' imprisonment (depending on the stage of the pregnancy) and/or payment of a fine. The only exception provided by the legislation is if the miscarriage was caused "in good faith", in order to save the mother's life. All respondents interviewed in the qualitative research were aware that there are legal prohibitions on abortion. While the majority of service providers were familiar with the specifics of the legal provisions – that abortion is legal when it is necessary to save the life of the mother – most young people and parents had limited understanding of the specifics of legal provisions concerning abortion, and reported simply that abortion is both illegal, and unacceptable according to social and religious norms. The absolute prohibition on abortion also serves to reinforce the stigma associated with sexual activity outside of marriage, and therefore may intensify social barriers to accessing contraceptives for unmarried young people.

Comprehensive sexuality education

There is no legal provision providing for comprehensive sexuality education in Sri Lanka. The government of Sri Lanka has articulated intentions to improve the quality and coverage of adolescent sexual and reproductive health education. At present, however, sexuality education in schools in Sri Lanka appears

to be insufficient and inconsistent, often because teachers are resistant to teaching it (for instance, due to pressure from parents). Indeed, many young people who participated in the research were poorly informed about sexual and reproductive health. Without education young people lack knowledge and information about the services that are available to them or how to access these services.

Laws that regulate sexual identity, behaviour and relationships

Legal minimum age of marriage

The Marriage Registration Ordinance (1908) sets the minimum age of marriage at 18 years for both men and women.[1] This does not apply to the Muslim community - no specific age of marriage is set out in the Muslim Marriage and Divorce Act 1954. The majority of respondents were aware that a minimum age of marriage exists in law, although some reported (incorrectly) that the age for girls is lower than the age for boys. The legal minimum age of marriage influences young people's access to services: young people, as well as parents appeared to believe that sex related services are not available to young people who are unmarried. This implies that minimum age of marriage laws may serve as an indirect barrier to access to services for 'underage' adolescents.

Statutory rape/minimum age of sexual consent

The minimum age of sexual consent is established in the Penal Code Amendment Act 1995 to be 16 for both boys and girls. The Penal Code Amendment Act establishes a lower age of sexual consent for girls who are married – 12 years of age. Most respondents were aware that the law establishes an age below which it is illegal for a person to have sex, and that sex with a person under this age is a criminal offence. Most participants (incorrectly) believed this age to be the same as the minimum age for marriage. Statutory rape and minimum age-based sexual assault laws were found to influence young people's ideas about the age at which it is acceptable to be sexually active and therefore to access SRH services.

Rape and sexual violence over 18

While sexual and domestic violence are legally prohibited in Sri Lanka, the law contains an important gap. Section 363(a) of the Sri Lankan Penal Code defines the crime of rape as non-consensual sex with a woman even where she is his wife (as long as they are judicially separated). In other words, marital rape is not legally prohibited in Sri Lanka. Section 365(b) of the Sri Lankan Penal Code also criminalises sexual abuse of male and third sex individuals, though this is not defined as 'rape' within the law.

Overall, research findings demonstrated that while respondents were aware that sexual and domestic violence are prohibited in law, these forms of violence occur with impunity. Reporting of incidents of sexual and domestic violence appears to be extremely low. Furthermore, no respondents in the qualitative research described a scenario (hypothetical or real) in which a man would be held legally accountable for physically or sexually abusing his wife, consistent with the lack of provisions criminalising marital rape within the law. Limited legal definitions of sexual violence, and abuse and lack of enforcement, create barriers to access to services. Survivors of abuse may be unwilling or reluctant to seek out services where they perceive their experiences as lacking validity or recognition, and providers may be less willing to offer support.

[1] *Marriage Registration Ordinance (1908), Article 15*

Protection of confidentiality

There do not appear to be legal or professional guidelines establishing requirements that a doctor keep patient information confidential.[2] While service providers participating in the qualitative research tended to maintain that they would protect young people's confidentiality in practice, both survey respondents and qualitative interviewees appeared confused and uncertain about the law on this matter. Data from the study indicates that the majority of children and young people do not consider themselves to have a legal right to confidential access to SRH services.

Reporting requirements

General circular no. 01-25/2015 published by the Ministry of Health and Indigenous Medicine establishes that reporting requirements under section 21 of the Code of Criminal Procedure Act do not imply a legal duty on health care workers to report to authorities if they learn that a person under the age of 16 is sexually active. Service providers appeared to view reporting requirements as discretionary, a position that is consistent with the circular. Young people and parents, particularly in Batticaloa, believed that unmarried young people who were found to be sexually active could be reported to child protection services and face legal repercussions, the most extreme of which involved being placed in a care centre ('probation centre').

Criminalisation of same-sex sexual activity

Section 365(a) of the Sri Lankan Penal Code provides that 'gross indecency'[3] between two persons is criminalised and punishable with imprisonment of up to two years or with a fine, or both, under the Penal Code (Amendment) Act 1995, section 365 (a). Despite the fact that legal provisions criminalising same sex sexual activity are reportedly no longer implemented in practice, many young people, including members of the MSM and transgender community, held the belief that both same-sex sexual activity and sex reassignment are illegal. Criminalisation and lack of recognition reinforce the stigma associated with alternative sexual behaviours and gender identities and create significant barriers to accessing services.

Criminalisation of sex work

While sex work in Sri Lanka is not explicitly criminalised, the Penal Code provides that a woman who engages in street sex work may be subject to arrest, detention and conviction under the Colonial Vagrants Ordinance 1842, which criminalises soliciting in a public place "for the purpose of the commission of any act of illicit sexual intercourse or indecency". Legal criminalisation of sex work reinforces the shame and disempowerment of women who sell sex and reduces their likelihood of seeking services. Women who sell sex included in the study were accessed through a support organisation that works in particular with sex workers and provides them with basic SRH services; however their responses suggest that they would be unlikely to seek other services elsewhere.

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[2] *It is very possible that such guidelines do exist, but we were unable to identify or obtain them in this study.*

[3] *This is generally understood to apply to same-sex sexual activity.*

Conclusions

The research indicates that the law creates a number of direct and indirect barriers to young people's access to SRH services in Sri Lanka. However, the law need not only serve as a barrier to access to services. Laws can also facilitate access, where they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. The research points to the need for a number of legal and policy reforms that have the potential to improve young people's access to SRH services in Sri Lanka.

Introduction

Whilst previous research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, as well as knowledge and perceptions of law, on access to services.

This is despite the fact that every state around the world, without exception, has developed legislation that is designed to regulate and restrict access to SRH for different groups of people in different circumstances. In recent years there has been a growing interest among SRH advocates and activists in exploring the interplay between legal frameworks and access to SRH services. This research project contributes to efforts to build evidence and knowledge in this area, in order to guide future advocacy and programming work, with the ultimate aim of fulfilling young people's right to sexual and reproductive health.

The research builds upon a similar pilot multi-country study conducted in El Salvador, Senegal and the United Kingdom in 2012 – 2013.

Key Concepts and Definitions

Adolescents, youth and young people: For the purposes of this study a **young person** was defined as anyone between the ages of 10 and 24 years, as per UN definition.[4] Sometimes the term 'adolescent' was used instead of child, to connote the social and biological stage of development that occurs between pre-pubescent childhood and adulthood.

A **child** was defined as any person under the age of 18 years, in accordance with Article 1 of the UN Convention on the Rights of the Child (UNCRC).[5]

Gender: Refers to socially constructed ideas, norms, roles and identities associated with being 'male' or 'female'. In this study, the germ 'gender' is used to describe socially constructed roles and identities that are assigned and negotiated on the basis of social and biological sexual differences.

Sexuality: is a broad term that refers to the way an individual expresses themselves as a sexual being. It may include a person's feelings, thoughts, attractions, preferences, as well as behaviour.[6]

Third gender: describes people who identify as a gender/ sex other than man/ male or woman/ female.

Transgender/trans: is an umbrella term used to describe a wide range of distinct groups of individuals who do not identify with the sex that they were assigned at birth. Transgender identity is not limited to, but may include, those who have undergone medical or legal identity transformation. Transgender individuals may self-identify as transgender, transsexual, female, male, hijra, kathoey, waria, or many others.

MSM: ('men who have sex with men') refers to all men who engage in sexual and/or romantic relations with other men. As used in this report and in line with the definition used by UNFPA, UNDP, UNAIDS, WHO and the World Bank, the term is "inclusive both of a variety of patterns of sexual behaviour by males with members of the same sex, and of diverse self-determined sexual identities and forms of sexual and social associations ("communities")."[7] MSM can include men who identify as gay or bisexual, transgender men who have sex with men, and men who identify as heterosexual.

LGBTI: Is a broad term that refers to individuals who are lesbian, gay, bisexual or transgender or intersex.

Sexual and reproductive health was understood as encompassing two related but distinct elements: health related to sexuality, and health related to reproduction.

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[4] *See page 2, UNFPA http://www.un.org./esa/socdev/documents/youth/fact-sheets/youth-definition.pdf accessed 2nd April 2016.*

[5] *UNCRC, "Convention on the Rights of the Child", 1990, retrieved on 26 January 2015 from http://www.ohchr.org/en/professionalinterest/pages/crc.aspx*

[6] *The University of Western Australia, retrieved 18 December, 2015, from http://www.student.uwa.edu.au/life/health/fit/share/sexuality/definitions*

[7] *United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf, accessed 14th June 2016.*

Sexual health implies that an individual has the freedom to have a pleasurable and safe sexual life, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[8]

Reproductive health implies that and individual has the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women and to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[9]

Sexual and reproductive health (SRH) services: in line with these definitions (above) the study will consider young people's access to services that are relevant to promoting and protecting sexual health and reproductive health. These will include, but are not limited to: education and counselling in relation to sexual and reproductive health, contraception, family planning, abortion, pre-natal and postnatal care, maternal and infant mortality, gender/sex reassignment services, and services related to the prevention and treatment of sexually transmitted infections (STIs) and sexual violence.

Sexual and reproductive rights: refers to an individual's right to have control over and make informed and free decisions on matters related to sexual and reproductive health, as well as their sexuality and sexual and reproductive life, free of coercion, discrimination and violence.[10]

Sexual and gender-based violence (SGBV) is a broad concept that refers to any action that is perpetrated against an individual because of sex, gender or sexuality and that results in, or is likely to result in, physical, sexual or psychological harm or suffering; including threats of such action or coercion. SGBV is committed for the purposes of maintaining (heterosexual) male/ masculine privilege, power and control over women, and others whose identity and behaviour does not conform to dominant ideas about gender, sex and sexuality.[11]

Sex work: refers to the exchange of sexual practice for money, goods or services by male, female or transgender individuals, aged 18 and over, who consider this activity to be a source of income, irrespective of whether they identify as "sex worker" or consider the activity to be "work". The internationally recognised definition of sex work excludes where a person is coerced into selling sex or is selling sex involuntarily.

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[8] *World Health Organisation, "Defining Sexual Health", retrieved on 30 September 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/*

[9] *World Health Organisation, "Reproductive Health", retrieved on 30 September 2015 from http://www.who.int/topics/reproductive_health/en/.*

[10] *For more detail on the range of sexual and reproductive rights, see the International Planned Parenthood's 'Charter Guidelines on Sexual and Reproductive Rights', available at: http://www.ippf.org/sites/default/files/ippf_charter_on_sexual_and_reproductive_rights_guidlines.pdf*

[11] *UNHCR, "Sexual and Gender Based Violence: Guidelines for Prevention and Response" Retrieved on Retrieved on 25 July 2015 from http://www.unicef.org/emerg/files/gl_sgbv03.pdf*

Conceptual Framework

This study was designed to examine the following:

1. The legal rules that regulate young people's access to SRH services, and how they are applied;
2. Young people and health professionals' knowledge of law, and how they perceive or interpret such laws as pertaining to themselves;
3. And, importantly, how law, and knowledge and perceptions of law, impact on young people's opportunities to seek out, and be provided, SRH services.

The relationship between law and access to SRH services

Law may influence or impact on young people's access to SRH services in various ways: the law may act as a barrier to young people's access to services through both directly and indirectly preventing access. In other cases, the law may actively facilitate, or promote, young people's access to services.

Direct legal barriers constitute laws which explicitly and/or purposefully restrict access to services, either universally or for certain groups of people in particular circumstances. For example, laws that restrict access to abortion (except in very limited circumstances) constitute **direct legal barriers.**

Indirect legal barriers are laws that do not directly impose restrictions on access to SRH services, but nonetheless may function this way in a particular context. For example, statutory rape laws, which establish a minimum legal age for consent to sexual activity, minimum age of marriage laws, and laws establishing a minimum age for legal majority, may create indirect legal barriers to young people's access to services. Young people and service providers may interpret these rules as forbidding young persons under these legal ages from accessing SRH services. Furthermore, these laws may have a normalising influence on existing social taboos associated with childhood and youth sexuality, particularly among unmarried girls.

Limited legal definitions of sexual violence and rape, which fail to recognise sexual abuse in all the contexts in which it occurs, such as the failure to explicitly prohibit rape within marriage may also create indirect legal barriers to access to services. Individuals may be unable to access support services, in contexts where experiences are not recognized, or are seen as lacking validity or importance.

The criminalization of homosexuality within Sri Lankan law can be understood as creating both direct and indirect barriers to you people's access to sexual and reproductive health services. On the one hand, these legal restrictions may actively prohibit the provision of certain services (including access to education and information, and others) required by young people in order for them to be able to have a healthy and satisfying sexual life (direct barrier). On the other hand, even where services do exist or are made available, some young people may be unable to access them due to fear of being criminalised or suffering discrimination and abuse on account of their sexuality (indirect barrier).

Finally, laws do not only function as barriers to accessing SRH services. Laws can also facilitate access to services, when they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. Confidentiality duties imposed on SRH service providers which mandate protection of young people's privacy and laws that promote sexual and comprehensive sexuality education (CSE) are examples of facilitative laws.

Methodology

1. Research Questions

Understanding the influence of law and legal rules on young people's access to SRH services in practice is a complex task. It involves understanding both what the law is, and how it is applied; as well as what young people and service providers know and understand about the law, and if and how such perceptions shape their choices, expectations and practices accessing or providing SRH services. Finally, it involves understanding how the law interacts with other key social, political, personal, economic (etc.) factors, which play a role in determining young people's access to services.

The following set of research questions were developed to gather information relevant to the areas set out above:

1. What are the direct and indirect legal barriers that influence young people's access to SRH services and how do they impact on young people's access?
2. What do young people know about the law as it applies to SRH services?
3. What do they know about the law as it applies to sexuality and sexual activity?
4. How do young people perceive or interpret such laws as applying to themselves or their peers?
5. How does this knowledge and perception influence their access to SRH services?
6. What are their experiences accessing SRH services and how do they expect this process to occur?
7. What are the gaps in their information and access?
8. How do legal barriers interact with social, cultural or other barriers to accessing SRH services?

2. Research Methods

The study employed a number of methodological approaches to answer the above research questions. To begin with, a desk-based review and analysis of existing laws and regulations was carried out in order to establish the content of legal provisions regulating young people's sexuality and access to SRH services.

Qualitative data was collected through individual interviews with SRH service providers (nurses, doctors, counsellors, etc.) as well as focus group discussions (FGDs) with groups of young people and parents. These qualitative interactions aimed to provide a more in-depth and contextual understanding of young people's and service provider's experiences of accessing/providing SRH services, and the relevance, role and influence of law: whether, how and why law has an influence in practice. In total, **120** respondents were accessed during the qualitative field research, which took place between the 2ndand 13th of November, 2015.

Finally, two quantitative surveys were distributed in-country – one to young people and one to service providers - to gather a limited amount of standardised and objective data concerning knowledge of relevant law, and SRH services seeking/ provision practices. Overall, surveys were distributed to 696 young people and 57 service providers.

3. Sampling

3.1. Site Selection

Selection of research sites was practically limited to include those locations where FPA were able to facilitate access to communities and respondents according to their existing networks.

Data was collected in the following sites:

	Colombo	Batticaloa District
Geographical location	Western/ central	Eastern, rural
Ethnicity	Primarily Sri Lankan Moor, Tamil, Sinhalese	Primarily Tamil
Economics	Relatively wealthy	Relatively deprived

3.2 Qualitative interactions: Interviews and FGDs

Sampling for the qualitative research was purposive, to ensure the inclusion of the views and experiences of a large range of different groups of young people, parents/ carers, and health professionals.

The sample of service providers interviewed included doctors, nurses, midwives, and NGO providers (educators/counsellors).

Participants in FGDs, including both young people and parents, were sampled purposively to capture the views and experiences of individuals from different age-groups, socio-economic, educational and religious backgrounds, to the greatest extent possible. Researchers also selected fir diversity with regard to sexual behaviour, identity and relationships, ensuring to inclusion of individuals of minority sexual and gender identities and those engaged in sex work or the selling of sex. Wherever possible, participants in FGDs were separated according to gender due to the sensitive nature of the issues under discussion.

3.3. Survey

Given time and resource constraints, it was not feasible to conduct a comprehensive, nationally representative survey. Nonetheless, two short survey tools were developed – one for young people and one for service providers – in order to collect some basic descriptive and standardised data that could be analysed objectively in relation to responding' knowledge, understanding and perceptions of law, and experiences accessing or providing services.

Respondents for the survey were accessed through institutions including schools and health services. Schools and health services were divided into strata according to whether they were public or private institutions, and whether they provided general or specialised services. Individual institutions were selected from within these strata, and the survey was then distributed randomly to young people and service providers within these institutions.

For a more detailed discussion of the study methodology, including sampling design and data analysis techniques, see Annex A. The 'interview schedule' used during the in-depth interviews with service providers can be found in Annex B. The 'group discussion schedule' used during the FGDs with young people and parents can be found in Annex C. The survey questionnaires are included in Annex D (service providers) and Annex E (young people).

4. Limitations

There are a number of methodological limitations in relation to the desk review, the qualitative interactions, as well as the quantitative surveys that need to be kept in mind when reading this report.

- While the desk review of the relevant legislation aimed to be comprehensive, not all potentially relevant materials (especially regulations and sub-national legislation) were available publicly and in English language. As a result, it is likely that at least some potentially relevant materials were not captured by the desk review. Whenever possible, researchers used officially translated English versions of the relevant legislation. However, in a few cases, researchers needed to revert to unofficially translated versions of legislation or regulations. These English translations were read and interpreted by researchers with the necessary amount of caution.
- Whilst participants in focus groups were separated according to gender and also divided according to age groups, it is likely that power dynamics within each group biased the discussions (and findings) in favour of the more outspoken and assertive participants. Researchers took care to enable equitable discussions amongst participants; however, participants that were too shy or afraid to answer were never singled out by researchers.
- Translators were used throughout the qualitative interactions. While emphasis was placed on literal translation of every statement and simultaneous translation was avoided, it is likely that some nuances of the participant's responses were 'lost in translation'.
- The implementation of the surveys (both with service providers and with young people) also entailed a number of methodological limitations. In practice, it was difficult to ensure that individual institutions were selected randomly from within the pre-specified strata, and that the survey was then distributed on a purely random basis to young people and service providers within these institutions. Researchers often needed to rely on the connections of the local IPPF member associations in order to gain access to particular target groups/institutions. This is likely to bias the discussion/findings in favour of target groups/institutions that had pre-existing connections to the local IPPF member associations. While care was taken to distribute questionnaires to a random selection of individuals within each selected institution or target group, surveys were filled out on a voluntary basis which is likely to have introduced some bias into the sample.
- Lastly, due to time and resource constraints (but also in order to ensure the confidentiality of the respondents), the survey questionnaires were self-administered. While enumerators instructed survey respondents on how to fill out the survey, the self-administered survey format resulted in relatively large non-response biases, as respondents were either unsure how (or unwilling) to fill out all questions in the surveys. Non-response was particularly pronounced in the service provider survey, which may be due to the time constraints amongst health professionals.

5. Ethical protocol and tools

The research process was guided by Coram International's Ethical Guidelines for Research (annexed at the end of this report). Prior to data collection taking place, the Director of International Programmes and Research, Professor Carolyn Hamilton, approved the research methodology, tools and ethical protocol. Ethical approval was also obtained from IPPF South Asia as well as FPA Sri Lanka.

An Ethical Protocol and tools (consent forms and information sheets) are attached at Annexes A and B.

Youth and Sexuality

6. Cultural Context: love, marriage and sexual relationships

In communities included in the study, dominant social norms dictate that it is unacceptable for unmarried young people to have sexual relationships. The power of social norms prohibiting sex outside of marriage was demonstrated by interactions with young people from diverse religious backgrounds and across research sites; young people emphasised that sex before marriage is wrong, and may result in serious negative consequences for young people and their families. When presented with a scenario of an unmarried friend or sibling who is considering having sex, young people in focus groups overwhelmingly responded that they would strongly advise their friend/sibling not to have sex *until she is married:*

Focus group discussion, young men, Colombo:

> *"Imagine that your 15 year old sister comes to ask you for advice because she is in a serious relationship and her boyfriend has started to ask her if she will have sex with him… what advice would you give to your sister?*
>
> *The sister should reject the boy's request because she is too young. There are cultural barriers and physically the girl is not ready. The culture is to be respected. After marriage, this is OK.*[12]

This norm was also reflected in survey data. When asked when it is appropriate for young people to become sexually active the majority of young people surveyed **(56.6%)**[13] responded 'when he or she is married', and nearly half of young people surveyed responded otherwise: **30.7%** selected 'at a particular age', and only **12.7%** selected 'it depends'. Those who specified a particular age may have been influenced by the legal age of marriage or ideas about when marriage is appropriate: the most frequently chosen age was **18 (the legal age of marriage)**. The mean age was slightly higher at **20.5 years**.

Respondents explained that engaging in pre-marital sex will compromise young people's honour and reputation, as well as that of their family. It is young women's and girls' sexuality, however, that is subject to the most social scrutiny and judgement. As explained by a group of girls in Colombo, 'If you get involved in that activity you will get scolded. The girl will lose her value and have a bad image in society – as will her parents and her relatives. People will not trust her. It will give a bad reputation to the school. We will feel ashamed'.[14]

Another group of young women explained that pre-marital sex undermines the commitments that accompany marriage, and can leave girls vulnerable to abandonment:

> *'To have a sexual relationship before marriage is difficult – some people leave home and go. If the boy and girl have sex without anyone else knowing it is not a sincere love – they will leave after some time. You are not responsible for anyone. You are not fearful of anyone. The boy is 18, the girl is 15… the girl gets pregnant. The boy is scared. He does not tell anyone at home. He will leave the girl.'*[15]

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[12] *Focus group discussion, young men, Colombo, Sri Lanka, 2 November 2015*

[13] *Of those respondents who answered the question.*

[14] *Focus group discussion, young women with disabilities, Colombo, Sri Lanka, 3 November 2015*

[15] *Focus group discussion, young men, Batticaloa, Sri Lanka, 4 November 2015*

The strength of the norm that sex should only occur within marriage (or cannot occur outside of marriage), is reflected by the fact that in communities included in the research respondents identified young people entering a sexual relationship as a cause of early marriage; the assumption being that if a young person becomes sexually active he or she will (must) get married:

Focus group discussion, mothers, Colombo:

> *Do young people in your community ever get in a girlfriend/boyfriend relationship before they get married?*
>
> *Some are married at an early age – they are facing some parent harassment because they are talking to some people, so they get married without their parents' permission.*
>
> *They can't control their feelings, so the boys and girls will get married at less than 18 – they know the law, that below 18 they cannot get married, but they start living together anyway.*[16]

Similarly, respondents explained that if an unmarried young person becomes sexually active, the solution to the situation would be for him or her to marry:

Focus group discussion, fathers, Colombo:

> *Now what would you do if you suspected your daughter was having a sexual relationship with a boy in the village?*
>
> *I will arrange for their marriage.*[17]

Conservative norms about pre-marital sex were reflected in participants' descriptions of traditional courting scenarios, which were particularly important in Hindu and Muslim communities[18], and according to which boys and girls do not spend time alone together and may not meet in person prior to their wedding:

Focus group discussion, young women, Batticaloa:

> *What type of relationships do you people have before marriage?*
>
> *The term relationship has different meanings. Sometimes it might be contact over the phone. Sometimes it might involve taking the families to your house.*
>
> *Can you meet up alone before marriage?*
>
> *No. According to Islam that is banned. You can't meet face-to-face before marriage.*[19]

These norms also explain stigma surrounding so-called 'love marriages', or marriages in which young people choose their partners themselves (as compared to traditional 'arranged' marriages, where a person is introduced to their spouse through their parents or other relatives). Arranged marriages were found to be dominant across research sites, and were seen as important, in particular, in order to maintain family networks that play an important role in ensuring the social security of the couple, and support for their marriage. Some respondents attached stigma to love marriages, because they pose a threat to these networks; *"[the marriages in our community are] mostly arranged – these are preferable because the father and the mother are choosing the partner so it will be preferable"*.[20]

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[16] *Focus group discussion, mothers, Colombo, Sri Lanka, 3 November 2015*
[17] *Focus group discussion, fathers, Colombo, Sri Lanka, 3 November 2015*
[18] *70.19% of Sri Lankans are Buddhists, 12.6% are Hindus, 9.7% are Muslims and 7.4% Christians (mainly Roman Catholic)*
[19] *Focus group discussion, young women, Batticaloa, Sri Lanka, 5 November 2015*
[20] *Focus group discussion, parents, Batticaloa, Sri Lanka, 4 November 2015*

Love marriages were reported to be both increasingly prevalent and acceptable, however. Young people described the emergence of a new 'category' of marriage, referred to as 'love-come-arranged' matches, whereby young people are able to choose their marriage partner, but do so in consultation with and with the approval of their parents.

Of course, particularly when researchers were able to establish an open and comfortable rapport with participants, they did acknowledge that young people do engage in sex outside of marriage in practice:

Focus group discussion, girls, Batticaloa:

> *Do the girl and boy spend time together before they are married?*
>
> *They will spend the night together.*
>
> *Do they start a sexual relationship?*
>
> *Yes, they do.*[21]

Acknowledging the disconnect between dominant social norms and young people's realities is crucial because, as this study will demonstrate, sexually active but unmarried young people face significant barriers to accessing SRH services based on their marital status.

7. Legal context: law, marriage and sexual consent

Just as marriage is a pre-condition for sexually activity, being of a sufficiently mature age is a pre-condition for marriage; and this is not only a matter of social norms, it is also a matter of law. In Sri Lanka, the Marriage Registration Ordinance (1908) sets the minimum age of marriage at 18 years for both men and women (the law was amended in 1995 to establish this minimum age).[22] Article 15 states that "no marriage contracted after the coming into force of this section shall be valid unless both parties to the marriage have completed eighteen years of age."[23] The Marriage Registration Ordinance does not apply to the Muslim community, who are governed instead by the Muslim Marriage and Divorce Act (1954). No specific age of marriage is set out in the Muslim Marriage and Divorce Act 1954, which law merely provides that in order to register a marriage where the girl is under 12 years, the quazi[24] in the area where the girl lives must authorise the registration of the marriage.

In Sri Lanka, statutory law does not include a legal prohibition of sex before marriage (although this may be the case for Muslim communities according to some interpretations of sharia law). The minimum age of sexual consent is established in the Penal Code Amendment Act 1995 to be 16 for both boys and girls.[25] It is interesting to note, however, that while the Act criminalises 'grave sexual abuse' of any person under the age of 16 (with or without consent), the crime of rape is defined as an act perpetrated by a man against a woman or girl.

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[21] *Focus group discussion, girls, Batticaloa, Sri Lanka, 4 November 2015*

[22] *Whilst Article 22 seems to imply that parents would be able to consent to marriage on behalf of their children who are below the age of 18, jurisprudence has clarified that this is not the case.*

[23] *Marriage Registration Ordinance 1908Art. 15.*

[24] *A judge ruling in accordance with Islamic religious law (sharia).*

[25] *Penal Code Amendment Act 1995 s 363 (e)*

Furthermore, and significantly, the Penal Code Amendment Act establishes a lower age of sexual consent for girls who are married; s363 states that a man who has sexual intercourse with a woman "with or without her consent when she is under sixteen years of age", commits rape, "unless the woman is his wife who is over twelve years of age and is not judicially separated from the man"[26] . This provision effectively legalises (statutory) rape by a husband of his wife in all circumstances as long as she is above 12 years of age.[27]

Laws that establish a minimum age for sexual consent, and for marriage, are purported to fulfil a protective purpose: to guard young people from exposure to rights violations (such as forced marriage or child sexual abuse). Yet these laws may also function to describe and prescribe particular ideas and values concerning age, gender, sexuality and marriage. This is demonstrated by the following interaction, in which respondents described that if young people were found to be having sex before marriage, the courts could force them to marry;

Focus group discussion, Fathers, Colombo:

> *If the boy won't marry her, I will take him to the courts.*
>
> *What would the charge be?*
>
> *The girl will go under an examination – to find out whether something is going on. If it is the courts will force him to marry her.*[28]

The quote above illustrates how respondents understood the law as functioning to uphold the norm that sexual activity is only appropriate within marriage, rather than protecting young people from exploitation or abuse. This is also demonstrated where the law differentiates between children who are married and those who are not. For example, the establishment of an exception to the minimum legal age of sexual consent for married girls (and the legal exception excluding all married women above 12 years from legal protection from rape by their husbands) is especially revealing: such a provision implies that early sexual activity is only harmful to girls where it takes place outside of the sacrosanct institution of marriage, and that (statutory) rape of a girl is criminal on the grounds that it violates social norms about the appropriate context for sexual expression and not because it violates the sexual autonomy of a girl/ woman.[29]

This analysis is important: whilst on the one hand, laws prohibiting early sex and marriage have the potential to protect children from exposure to rights violations, such as rape, forced marriage and a range of risks to their physical and mental health, including complications during pregnancy and heightened risk of HIV and other STI infection; on the other hand, they may function to deny children and young people basic human rights, including to sexual and reproductive health, as well as inhibiting their access to vital services, through reinforcing dominant and gendered norms which define what is considered acceptable and unacceptable (sexual) behaviour. These issues are explored further below.

Law both reflects culture, and reinforces ideas about what is 'acceptable' and 'unacceptable' (sexual) behaviour. Laws prohibiting early sex and marriage have the potential to protect children from rights violations such as rape, forced marriage, and risks to their physical and mental health. On the other hand these laws may also function to deny children and young people basic human rights, including access to SRH services.

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[26] *Penal Code Amendment Act 1995 s 363 (e)*

[27] *Acts that amount to rape under s363 of the Act are not covered by s365 (Grave sexual abuse).*

[28] *Focus group discussion, fathers, Colombo, 3 November 2015*

[29] *Yarrow et al., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014*

Access to Services

8. Access to contraception, STI testing and other basic services

8.1 The law

Sri Lankan statutory law does not contain specific provisions in relation to young people's ability to consent to medical treatment. There is, however, official policy guidance, which addresses the capacity of children to consent to access SRH services.

General Circular no. 01-25/2015, issued by the Ministry of Health and Indigenous Medicine, provides that Adolescent Sexual & Reproductive Health (ASRH) services may be provided to a minor under the age of majority, which is 18 years according to the Age of Majority Amendment Act No. 17 of 1989, irrespective of parental consent, if it is likely that the minor will engage in sexual intercourse which will be 'detrimental' to their physical or mental health without the provision of the service.

General Circular no 01-25/2015: Consent to Access ASRH Services

The circular defines ASRH Services comprehensively to include: pregnancy care; care for pregnant mothers (antenatal care); care during delivery (intra natal care); care for lactating mothers including post- natal care; contraceptive and family planning services; post abortion care; prevention, care and management of STI and HIV /AIDS; prevention, care and management of gender based violence".

Significantly, the circular states that it applies to 'adolescents', 'adolescence', and 'young people', but these terms are not defined; so it is not clear whether this circular is intended to apply to all young people (as defined in this study as any person aged 10 years and above).

Furthermore, while the circular allow for the provision of SRH services to a minor without parental consent, the circular states that the medical officer must nonetheless take 'all reasonable measures' to obtain parental/guardian consent prior to providing those services 'considering the norms of the country'. If this is not possible, however, the health care provider should still provide the services in the best interest of the child.

The circular has several important implications for young people's access to SRH services. Firstly it appears to indicate that the legal age of majority[30] (18 years)is presumed to establish the general rule for when a person is able to independently consent to access services (i.e. a service provider is no longer required to take all reasonable measures to secure parental consent before providing the service). Secondly, the circular establishes a general presumption that parental consent is desirable in the case that a minor (person under 18 years) is accessing to SRH services, and that this consent should be sought as far as possible, in line with 'the norms of the country'. Thirdly, the circular establishes that provision of SRH services to an adolescent is at the discretion (determined on a case-by-case basis) of the service provider. Finally, it establishes that an adolescent's ability to access services is not an absolute right, but rather something which they are granted only when denying access to the service would be detrimental to their physical or mental health.

Despite these restrictive aspects, the circular is largely permissive in the sense that it firmly establishes an obligation on service providers to provide a young person access to services if it is deemed in their best interests, even in the absence of parental consent.

[30] *The Age of Majority (Amendment) Act (No. 17 of 1989) defines the age of Majority - general legal capacity - at 18 years*

8.2 Service providers: knowledge, perceptions and practices

Service providers interviewed in the qualitative research generally expressed the view that children and young people have the right to access SRH services, and that there is no legal or policy barrier to the provision of services to these groups.

Interview, Midwife, Batticaloa

> *Is there a minimum age before you will provide contraceptives?*
>
> *Age? We don't go according to age, but according to choice. Everyone has the right – it's their choice.*[31]

Interview, Nurse, Colombo

> *Are there any legal restrictions on your ability to provide services to young people?*
>
> *School students do not come to take services in this clinic, but I can provide them if they do come. According to my knowledge, there is no law on this. I don't believe there should be a barrier to accessing these services.*[32]

These permissive attitudes are consistent with recent steps taken by government to introduce facilitative policy granting 'minors' independent access to SRH services and other medical treatment (see above).[33]

A majority of services providers in the survey, 70.6%, stated, however, that they are only legally able to provide access to SRH services to a minor after assessment of the young person's capacity. Although these findings may appear to some extent inconsistent with each other, they are nonetheless broadly aligned with government policy that provides that adolescents may be provided SRH services, but at the discretion of the service provider and in consideration of the adolescent's best interests.[34]

Whilst a majority of service providers interviewed stated that they are able in law to provide a young person services regardless of age, they also emphasised that very few young people tend to access their services in practice; as one Doctor in Colombo explained: *"There is no [legal] barrier to young people accessing services. We don't see them [at the clinics] but maybe that's because they are not aware;"*[35] *and a nurse similarly told researchers: "If young people would come here and request contraception then we would give it to them. But young unmarried people will not come here asking for that. They will not report to us. They are shy."*[36]

As these extracts suggest, service providers felt that social and cultural barriers to accessing SRH services, such as feelings of shame, and a lack of awareness and education about SRH amongst young people, have more influence on young people's access to services, than provisions contained in law.

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[31] *Individual interview, midwife (female), Batticaloa, Sri Lanka, 4 November 2015*

[32] *Individual interview, nurse (female), government clinic, Colombo, Sri Lanka, 2 November 2015*

[33] *UNESCO, Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services(Bangkok: UNESCO, 2013), p. 34, accessed 5th October 2015 http://unesdoc.unesco.org/images/0022/002247/224782E.pdf*

[34] *UNESCO, Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services(Bangkok: UNESCO, 2013), p. 34, accessed 5th October 2015 http://unesdoc.unesco.org/images/0022/002247/224782E.pdf*

[35] *L1 Individual interview, FPA Doctor (male), government clinic, Colombo, Sri Lanka, 2 November 2015*

[36] *L4 Individual interview, nurse (female), municipal council clinic, Colombo, Sri Lanka, 3 November 2015*

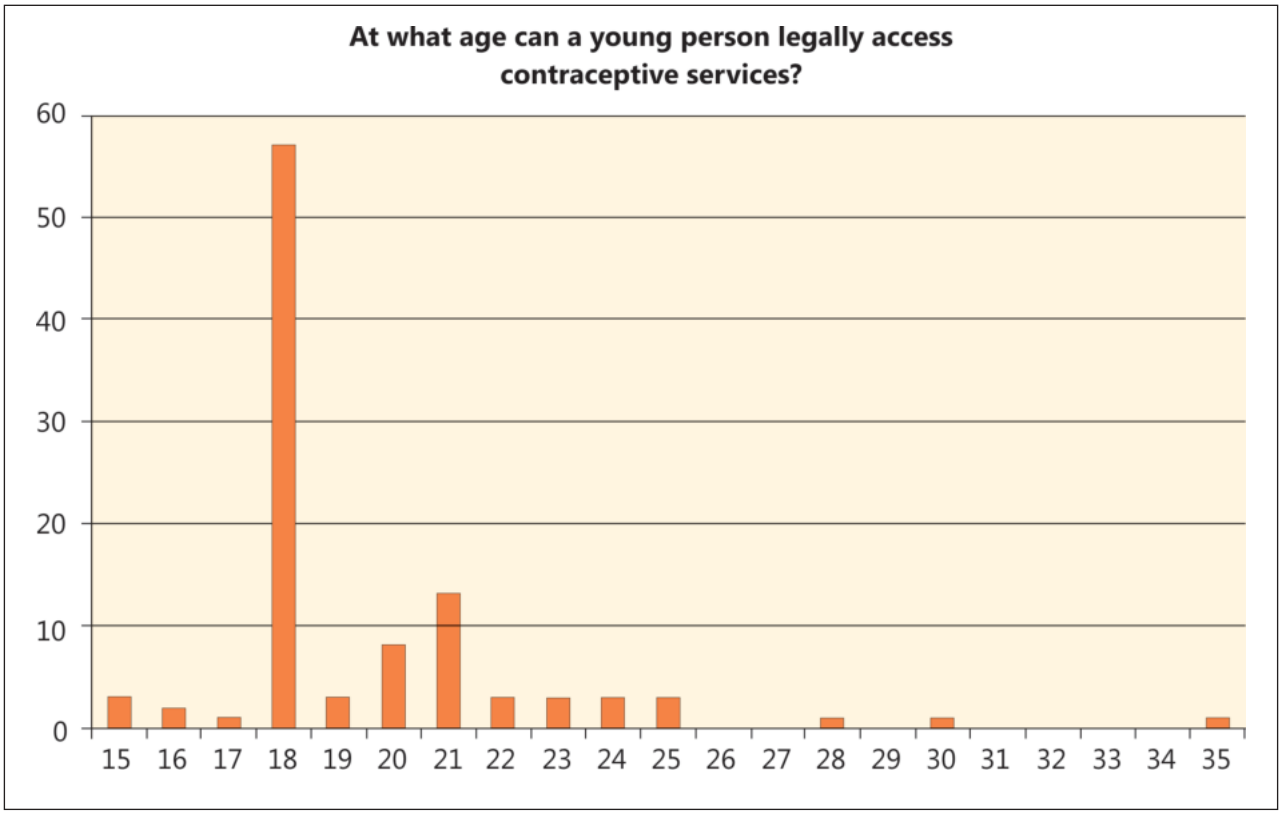
8.3 Accessing contraceptives and STI services: young people's perceptions and practices

8.3.1 Perceptions of legal restrictions on access to SRH services

In contrast to service providers, the majority, **61%**, of young people in the survey reported that there are legal restrictions on minors' access to SRH services. Around a third of all young people surveyed, **32.5%**, reported that the law establishes a precise age threshold for access to SRH service and **28.6%** felt that legal access depends on the discretion of the service provider (the remaining **39%** did not think that there are any legal restrictions based on age).

Those young people who did think that the law established a particular age threshold for legal access to SRH services were asked to specify which age they thought this was: respondents gave widely variant responses to this question, ranging from 15 years to 35 years.

Figure 2: At what age can a young person legally access contraceptive services?



As the above graph demonstrates, however, the overwhelming majority of respondents who believed that there is a legal age for access to SRH services, believed this age to be 18 years. This is not inconsistent with the law: as mentioned, the age of majority in Sri Lanka is 18 years, and General Circular no. 01-25/2015 establishes that there are special provisions for access to SRH services for a person under 18 years.

When young people were asked in qualitative interactions why children under the age of 18 years are not able to access SRH services, however, respondents rarely identified direct legal barriers to access. Instead, they typically emphasised that it is considered socially and culturally inappropriate to provide SRH services to a 'school' child, who is not yet married(the importance of marriage on access to services, and the influence of law in this respect is discussed in detail in Section 8.3.2 below).

In addition, respondents - especially those from Muslim backgrounds and in the Eastern Tamil region - tended to express the view that providing SRH services can be harmful to a young person's health, particularly in relation to fertility:

> *"I am thinking that family planning is dangerous. It is not good because it's harmful to the baby. Contraception causes a woman's womb to get smaller and because of that the woman will not be able to conceive again;"*[37]

> *"By using tablets the female gets weakness in her body. Islam prefers the withdrawal method. By using [contraceptive] pills women get high blood pressure."*[38]

Interestingly, these attitudes and (mis-)perceptions were not limited to forms of contraception used by women and girls; a group of boys in Batticaloa told researchers: *"there are some side effects [to condoms]. Like HIV – condoms can cause HIV. And infertility."*[39] The boys' responses reflect the fact that they were extremely uninformed about sex and reproduction, but did have ideas that contraception use is harmful.

Respondents also emphasised that contraceptives are not relevant to (young) people because it is considered desirable and good to have children: *"using condoms is not ok according to Islam. According to Islam it is ok to have lots of babies. God will take care of them. The use of contraceptives in the Islamic community is very less."*[40]

Indeed, evidence from the survey suggests that few young people are accessing SRH services in practice. Less than a quarter, **22.6%** of young people sampled in the survey reported to have attempted to access a type of contraceptive service (including condoms, birth control pill, IUD or injections), and only **3.1%** reported to have attempted to access an STI test. Male respondents (**5.5%**) were significantly more likely than female respondents (**1.2%**) to say that they had accessed an STI or an HIV test;[41] they were also overwhelmingly more likely to report having accessed a condom (**21.4%** of boys, compared to only **7.4%** of girls). This is likely the consequence of discriminatory attitudes towards gender and sexuality (explored further in section 13) which dictate that pre-marital activity is particularly shameful and ruinous for girls; as a child in the qualitative research explained: *"only boys can access condoms – ladies will not go to access those. Girls will be afraid according to our culture… A woman can't be bold like a man."*[42]

Significantly, almost half (**47.5%**) of young people who reported having accessed contraceptives, and as many as **71.4%** of young people who had accessed an STI or HIV test, reported that they had been denied access to this service. Importantly, respondents under the age of 18 years at the time of the survey were significantly more likely to report having been denied access to an SRH service than respondents over the age of 18 years[43]. as many as **92.9%** of respondents under the age of 18 years who reported having tried to access any SRH service, reported that they had been denied access on at least one occasion. This is inconsistent with responses from service providers, the majority of whom explained that they would not deny a young person access to SRH services in practice.

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[37] *Individual interview, nurse, Batticaloa, Sri Lanka, 4 November 2015*

[38] *Focus group discussion, young men, Batticaloa, Sri Lanka, 5 November 2015*

[39] *Focus group discussion, boys, Batticaloa, Sri Lanka, 5 November 2015*

[40] *Focus group discussion, young men, Batticaloa, Sri Lanka, 5 November 2015*

[41] *Chi-square test, $p<.05$*

[42] *Focus group discussion, boys, Batticaloa, Sri Lanka, 4 November 2015.*

[43] *Chi-square test, $p<.01$*

The majority of young people believed there are legal restrictions on their access SRH services, however when asked to elaborate why young people are not allowed to access services they described socio-cultural barriers rather than restrictions on access established by law.

Only a minority of young people in the survey reported to have ever accessed an SRH service; boys were more likely to report accessing services than girls, and older respondents were more likely to report having (successfully) accessed services than those who were younger, suggesting that access to SRH services is affected by both gender and age.

8.3.2 Influence of the child marriage law

Many young people, as well as parents, appeared to believe that sex related services are not available to young people who are not yet married. When asked: 'in your view, at what age should a young girl be able to access contraceptives', over half of respondents (52.2%) stated that she should not be able to do so until she is married. Of the 52.2%, the vast majority (79.3%) stated that she should only able to do so 'once she is married and has already had her first child'. This view, which reflects strong social expectations that women do not have sex before marriage and will have children soon after marriage, was echoed by respondents who seemed puzzled by the suggestion that a young person would want to access contraceptives at all.

The view that contraceptives are not available to unmarried young people likely reflects the intensity of social stigma surrounding pre-marital sex. In such a context, accessing contraceptives would require a young person to acknowledge that he or she has transgressed a norm to an adult authority (service provider), an act that might seem unthinkable, particularly for girls: "[an unmarried girls] will fear about going to the doctor... indulging in sex before marriage is a very bad thing. How is she going to explain this to the Doctor?"[44] A group of mothers in Ahmedabad also explained: "Basically the medicine is for the girls to prevent pregnancy. So if she is taking the medicine when she is unmarried it is a sign that she is going down the wrong direction – she is going down the wrong path".[45]

Interestingly, female respondents were more likely than male respondents to express the view that girls should only access contraceptives when married. This is likely due to the fact that, as previously discussed, the stigma surrounding pre-marital sex is particularly strong for girls and young women; as a group of young people in Batticaloa explained: "Boys can do anything...the wrong is on the female partner. She is the one who should take precautions. She should be careful. She should understand the problems it will cause".[46]

There is no legal rule that prohibits unmarried youths from accessing contraceptives and other SRH services; barriers are created by social, cultural and religious norms that prohibit sex prior to marriage. Nonetheless, the legal minimum age of marriage may serve as an indirect legal barrier: if social norms prohibit sex before marriage, and the legal minimum age for marriage is 18 years, it follows that persons under this age should not be accessing SRH services. Indeed, evidence from qualitative interactions suggests that young people's perceptions about when adolescents can legally access SRH services are influenced by the law on the minimum age for marriage. For example:

[44] *Focus group discussion, young women, Bangalore, 29 October 2015*

[45] *Focus group discussion, mothers, Ahmedabad, 27 October 2015*

[46] *Focus groups discussion, mixed young people, Batticaloa, 4 November 2015*

Focus group discussion, boys, Batticaloa

At what age do young people start having sex?

18 or 19 years.

After marriage.

Always after marriage?

Yes.

Why is that?

It is our tradition. If they are not married – in the case that a boy and a girl are having a sexual relationship, and she conceives, then the boy may run away and abandon the girl, so it is to avoid that situation.

What about contraception to prevent pregnancy?

According to the law that is banned. But there are tablets and pills… According to our religion and customs a man and a woman should be married before they start having sex. If they are caught having sexual activities they can be arrested under the prostitution act.

Before you said that contraceptive pills and tablets are illegal – can you tell me more about that?

It is not legal before marriage to be involved in those activities, so it is illegal to obtain those pills – it is a crime. Even if we consult with a doctor – before we are married they will not give us those pills. In the pharmacies you can get them but people might arrest you. But some people might decide that they make good money so they will sell it to you.[47]

The interaction above demonstrates how young people's understandings of barriers are linked explicitly to the legal minimum age of marriage. As put more succinctly by another group of boys:

Focus group discussion, boys, Batticaloa:

Do you have any recommendations for improving young people's access to SRH services?

Only if we get married – then only we will get legal access to SRH services. If we are in a legal marriage we can do everything.[48]

In sum, findings suggest that, together with norms which prohibit sexual activity outside of marriage, the legal minimum age of marriage does influence young people's access to sexual and reproductive health services, by reinforcing the perception among young people that if you are unmarried and under 18 you should not be accessing services.

Such perceptions are likely to be reinforced by (the threat of) the application of legal responses to under-age sex, which reinforce the notion that the sexual activity of (unmarried) young people is legally forbidden.

[47] *Focus group discussion, boys, Batticaloa, Sri Lanka, 5 November 2015*

[48] *Focus group discussion, boys, Batticaloa, Sri Lanka, 4 November 2015*

8.3.3 Influence of age of consent law

These barriers may also be reinforced by the minimum legal age of sexual consent. The vast majority, **77.5%**, of participants in the survey, identified that law does establish a minimum age at which it is legal to have sex; though the majority incorrectly identified the age of sexual consent to be 18, which may indicate the influence of the legal minimum age of marriage on young people's ideas about when sex is both acceptable and legal.

While, as previously discussed, the majority of service providers in Sri Lanka emphasised that there aren't legal prohibitions on young people's access to SRH services, and that they would not deny young people access to services in practice, survey data suggests that those who did identify legal restrictions on young people's access may have been influenced by the legal age of sexual consent: service providers who thought it is illegal to provide contraceptives to a young person under the age of sexual consent were more likely to consider there to be legal restrictions on young people's access to SRH services based on age than those who did not.

The law on sexual consent also appeared to have a significant normative influence on young people and parents, in particular through shaping their ideas about socially acceptable and unacceptable behaviour, and in turn impacting on their access to SRH services. This was evident in the ways that respondents conflated restrictive narratives and stigma concerning young people's sexuality with their ideas about legal definitions and rules. Consider the following excerpts:

Focus group discussion, boys, Batticaloa:

> *Do you know if there is a law about at what age a person can start having sex? 18 years.*
>
> *What happens if someone violates the law?*
>
> *If we don't follow the law we might get in trouble – the girl might get pregnant… According to Islamic law we will throw stones at a woman / girl who has a baby outside of marriage.*[49]

Focus group discussion, boys, Colombo:

> *If a 15-year old friend came to you for advice because she was thinking of having sex with her boyfriend, what advice would you give her?*
>
> *…It is wrong. The girl is 15 years old and it cannot be accepted.*
>
> *What if your friend decided to go along with the situation (have sex with her boyfriend) – what advice would you give her?*
>
> *The government law is that you can't get married before 18. This is due to threats like that mentioned in the situation (pressure to have sex outside of marriage).*[50]

The boys perception of the law in the second excerpt is particularly revealing: they state that it is unacceptable for their 15 year old friend to have sex, and that the law which establishes 18 as the minimum legal age of *marriage* prohibits her from doing so. The boys' understanding of the reason for this law (circularly) is to protect young people from the 'threat' of being pressured to have sex before marriage.

[49] *Focus group discussion, boys, Batticaloa, 5 November 2015*

[50] *Focus group discussion, young men with disabilities, Colombo, 2 November 2015*

The fact that the law on sexual consent is understood as a measure to uphold socially dominant norms about appropriate sexual behaviour (rather than to protect a child from non-consensual sex) was also reflected in respondents' explanations of when and why the law on sexual consent/ statutory rape is typically applied: participants raised examples of how the law may be used by parents to maintain control over their children's relationships, or to preserve the honour of a girl who has engaged in sex before marriage; as previously mentioned, respondents described that the threat of criminal prosecution is sometimes used by parents to pressure a boy into marrying their daughter after having learned that they are involved in a sexual relationship.

Additionally, in Batticaloa, several respondents explained that when unmarried young people engage in sexual activity, they will be taken into the custody of child protection services and placed in what respondents described as a 'hostel', or a 'probation facility:

Focus group discussion, boys, Batticaloa:

> *What happens if people get married under the legal age? Are there any consequences?*
>
> *If both parties love each other, but they are under 18 years their parents will file a case to the court, and the court will separate them apart and put them on probation.*[51]

This example is consistent with other cases mentioned by respondents in Batticaloa, who explained that if a girl becomes pregnant before she is married or engages in pre-marital sex, she will be placed in a child protection facility until she is finished with school or old enough to marry the child's father (the 'perpetrator):

Focus group discussion, parents (mixed), Batticaloa:

> *There was a girl who had been offended by a person – she was raped and got pregnant…when the teacher found out that she was pregnant, the baby was delivered at the probation department with the police guard. The victim and the baby were under probation because the girl's age was under 15. The baby and the mother are kept because when she returns at the age of 15 she will marry the perpetrator. She is kept there for her own safety.*
>
> *What are your views about this?*
>
> *Yes, it is correct. The girl wants to obey the law. When both parties reach the appropriate age, then they will marry. This will happen when the girl is around 17-18 and the boy is around 21.*[52]

The girl's placement in the centre was justified (and most likely legally categorised) as a measure taken for her protection – in a context where abortion is illegal, and to be pregnant as an unmarried woman is deeply stigmatised, removing the girl from her social context is perhaps seen as the only way to avoid subjecting her to several forms of violence of which she is at risk: either 'early marriage' (the solution to 'early pregnancy' which would be applied by her community), sexual abuse (continued 'illegal' sexual interaction with the child's father), or (if she were to remain unmarried) verbal and physical abuse suffered at the hand of the community due to her socially unacceptable position.

[51] *Focus group discussion, boys, Batticaloa, Sri Lanka, 4 November 2015*

[52] *Focus group discussion, parents (mixed), Batticaloa, Sri Lanka, 4 November 2015*

For respondents, whether the sexual activity was or was not factually consensual appeared to be largely irrelevant to the legal response; this is consistent with pervasive narratives across research sites, according to which all sexually activity outside of marriage is considered to be abuse and no sexual activity within marriage is considered to be abuse. These narratives appear to have shaped the application of the law, such that the father of the child is considered to be the perpetrator from whom the girl requires protection until she is old enough to legally marry him at which point he becomes her husband. Again, we see legal provisions intended to protect young people from sexual exploitation (i.e. statutory rape and child marriage laws) primarily applied in order to prevent socially unacceptable (pre-marital) sexual relations. The relevance of this analysis for shaping access to SRH services, particularly sexual and gender based violence (SGBV) services, is explored more in 13.

Evidence from the qualitative research indicates that the minimum legal ages for sexual consent and for marriage function as indirect barriers to access to services for children under these minimum ages. These legal minimum ages were found to both influence young people's ideas about when it is legal to access sex-related services and to reinforce social, cultural and religious norms which prohibit young unmarried people from engaging in sexual behaviour and thus stigmatise their access to services.

8.3.4 Young married

It is important to acknowledge, that although being young and unmarried causes significant barriers to access to SRH services, there are also substantial – albeit different – barriers faced by young people, particularly girls, who are married, for reasons related to their marital status. Young brides are often under considerable social pressure to demonstrate their fertility by getting pregnant at the earliest opportunity. This trend was demonstrated by the fact that many service providers and young people alike described that a young woman would only access contraceptives after she had her first child:

Focus group discussion, young people (mixed), Batticaloa:

Do you have any recommendations for improving young people's access to SRH services?

After young people deliver their first baby, they should provide contraception to them.[53]

Furthermore, it may be difficult for young women to access contraceptive services without the knowledge and approval of their husbands. As one service provider interviewed for the study in Colombo explained:

Focus group discussion, doctor, Colombo:

We will take a request letter from the parents. It is required to have a letter if you are less than 16. Above 16 there are no problems if the husband and wife come together.

What if the lady comes alone?

They will ask her to bring her parents or her husband.[54]

[53] *Focus group discussion, young people, Batticaloa, Sri Lanka 4 November 2015*

[54] *Individual interview, doctor, public clinic under Colombo municipal council, Colombo, 3 November 2016*

9. Access to confidentiality: age of consent and mandatory reporting requirements

Shame and embarrassment were the most common explanations given by young people and service providers alike when asked why young people don't access services such as contraceptives and testing. Young people fear being seen going to a clinic because people who see them will assume they are sexually active and pass judgement, especially if they are not married.

Where young people don't feel their privacy will be protected, the shame and embarrassment of accessing services is compounded and can be prohibitive. Many participants explained that young people are not going to clinics for fear someone would find out – 'they gossip'. Confidentiality is important to young people, and the fear that it will not be protected serves as a significant barrier.

9.1 The law

The Sri Lanka Medical counsel is a statutory body established in order to maintain professional standards, discipline and ethical practice within the medical profession. However it does not appear to have published guidelines on doctor-patient confidentiality, including with regard to the confidentiality of the treatment of young people.[55] The apparent lack of legal provisions clearly establishing a young person's right to confidentiality is an important gap since an absence of legal clarity is likely to lead to ambiguity about the confidentiality of services, creating a barrier to access.

In fact, the only legislation which facilitates young people's access to confidential SRH services is the Sri Lankan general circular no. 01-25/2015 published by the Ministry of Health and Indigenous Medicine. The circular establishes that reporting requirements under section 21 of the Code of Criminal Procedure Act do not imply a legal duty on health care workers to report to authorities if they learn that a person under the age of 16 is sexually active.[56] This has implications for the ability of under 16s to access services confidentially, as without this provision, legally, service providers would be required to violate doctor patient confidentiality for girls who are pregnant under the age of 16 or under 16s accessing sex-related services.

Importantly, the circular sets outs that when providing reproductive health services to adolescents the best interest of the child should be the basic concern and that such decisions will need to be made by the health care provider on a case by case basis. As previously noted, the circular does not define adolescent and thus it is unclear to which ages it applies.

While the government circular is relevant to young people's confidential access to services both directly, through removing the requirement to report under-age sex, and indirectly, through implying that service providers should provide confidential access to services if this is in the child's best interest, it does not establish that young people have a right to access services confidentially. In fact, there do not appear to be any provisions that place an obligation on health care providers to protect patient confidentiality.

While the removal of mandatory reporting requirements has is likely to have improved young people's access to confidential health services in Sri Lanka, a lack of provisions which establish children's legal right to have their confidentiality protected when accessing SRH services may serve as a significant barrier to access.

[55] *It is very possible that such guidelines do exist, but we were unable to identify or obtain them in this study.*

[56] *Ministry of Health and Indigenous Medicine (2015) Providing Sexual and Reproductive Health (SRH) Services to Adolescents, 01-25/2015.*

9.2 Data from service providers

Service providers included in the survey were asked a series of questions about the law and confidentiality as it relates to children accessing SRH services under the age of 18 years. Their responses to these questions yielded highly contradictory results, indicating that there is a considerable amount of confusion and uncertainty amongst service providers about the law on this matter.

Many service providers surveyed did identify protecting young people's confidentiality to be a legal priority; when asked to agree or disagree with the statement, 'according to the law I am required to protect a minor's confidential access under all circumstances', **over 80%** of respondents in Colombo and **around 50%** of respondents in Batticaloa agreed with regard to access to condoms, injections, the oral contraceptive pill, IUDs, implants, STI and HIV testing. It is clear from qualitative interviews that service providers in both Colombo and Batticaloa tended to maintain that they do (or would) protect young people's confidentiality in practice:

Interview, Doctor, Colombo

> *What would you do if a 15 year old came to you and said they were sexually active and wanted contraceptives?*
>
> *I would explain to them the different methods for preventing pregnancy and then I would provide.*
>
> *Are you required to keep it confidential?*
>
> *Yes.*
>
> *Is that the law?*
>
> *It is according to the medical code of ethics.*[57]

Interview, Doctor, Colombo

> *Would you be required to keep it confidential if a young person came to access services?*
>
> *Yes.*
>
> *Is that the law?*
>
> *We received some training from the government. They said that we should keep patient's information private.*[58]

Service providers also emphasised that maintaining young people's confidentiality is critical to promoting their access to services. Service providers generally attributed young people's resistance to accessing services to embarrassment or 'shyness' in the context of strong cultural taboos regarding pre-marital sex, and explained that in this context privacy is a priority for young people. As put by a doctor in Colombo:

Interview, Doctor, Colombo

> *What are the biggest challenges young people face accessing SRH services?*
>
> *The big problem is the cultural barriers – we are willing to give them but they are too shy.*
>
> *Would women be less shy if you did not require a letter from their parents or husband?*
>
> *Yes.*[59]

[57] *Individual interview, doctor, Colombo, Sri Lanka, 2 November 2015*
[58] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*
[59] *Individual interview, nurse (II), Colombo, Sri Lanka, 3 November 2015*

Indeed, a service provider at a government clinic explained that because young people 'have to go to the government clinic in their own area'[60] they tend to prefer to go to private clinics some distance from their community in order to protect their anonymity.

Yet even while service providers emphasised the importance of maintaining confidentiality when young people access services, most service providers reported to believe that the law permits them to compromise confidentiality in certain circumstances: around half of the service providers (who responded to the question) agreed with the statement 'According to the law I am only permitted to inform a minor's parents (w/o her consent) if there is a risk to her health' for all SRH services associated with being sexually active, and 69.2% of respondents reported being required in law to inform a child's parents if he or she accessed condoms, injections or the OCP. Over three quarters (75.9%) of the 69.2%who reported being required to inform a child's parents had also agreed that they are legally required to protect a young person's confidentiality in all circumstances.[61]

It is difficult to make sense of these inconsistencies: perhaps from the perspective of service providers informing a child's parents of his or her access to SRH services is not a breach of confidentiality, because a child remains in the custody of his or her parents until the age of 18. Finally, service providers' tendency to agree with conflicting statements about the law may also reflect recognition of competing priorities, which cut to a fundamental tension at the heart of child policy: on the one hand children are rights holders, with capacity and autonomy, on the other hand they are a socially subordinate group, defined by their dependency and need for protection.[62]

The contradictions expressed by service providers suggest that they see their legal requirements regarding confidentiality as ambiguous, reflecting the lack of clarity and space for discretion that exists in actual law. As mentioned in the findings from the legal review, the Sri Lankan Ministry of Health recently issued a circular clarifying that non-disclosure of rape does not fall within the scope of the Code of Criminal Procedure Act, effectively removing the legal duty for medical health providers to report to child protection authorities when they learn a child is sexually active under the age of 16.[63] This appears to be an acknowledgement of the barriers a reporting requirement would create for young people's access to services; as a service provider in Batticaloa explained: "Earlier there was a circular that said if a child is under 16 you should report this to the police. Then the higher authorities said, do not inform the police because no one will come! This happened around 2010. The chief justice said we should provide (contraceptives). We are no longer reporting cases. They should not have fear to access services".

It seems the Sri Lankan courts were forced to confront a tension between promoting young people's confidential access to services and protecting them from exploitation and abuse. In this sense, it is a positive development that the reporting requirement written into the law was recognised as a legal barrier and removed.[64]

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[60] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*

[61] *No service providers in Colombo responded to this question.*

[62] *Yarrow et al. ., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014*

[63] *Ministry of Health and Indigenous Medicine (2015) Providing Sexual and Reproductive Health (SRH) Services to Adolescents, 01-25/2015.*

[64] *Individual interview, doctor, Batticaloa, Sri Lanka, 5 November 2015*

When asked whether they had ever reported a case where a minor was sexually active under the age of 16 to the police/child protection services, **44.1%** of service providers surveyed in Batticaloa and **36.0%** of service providers surveyed in Colombo answered yes.[65] When asked what happens if he or she fails to report a case, all service providers in Colombo (who responded to the question) answered 'nothing at all', a view which is consistent with the content of the circular. In Batticaloa, however, **17.2%** of respondents answered 'I risk going to jail' and **27.6%** responded 'I risk losing my job', indicating, problematically, that they are not aware of, or do not understand the circular.

Service providers interviewed as part of the qualitative research suggested that cases of under-16s accessing services are rarely reported to the police or child protection services in practice; although not all service providers referred to the specific legal guidelines set out in the circular, service providers were generally aware that they are not legally required to report under-age sex to relevant authorities (police or child protection) as a legal requirement:

Interview, nurse, Colombo:

> *Do you have any child protection reporting requirements or obligations?*
>
> *I have no idea about this.*[66]

Interview, doctor, Colombo:

> *If someone comes to you and reveals that they are having a sexual relationship under the age of 18 years, is it your duty to report this?*
>
> *There is no need to report.*
>
> *At any age? What if the child is really young…*
>
> *There is no age at which we think that we should report.*[67]

Given that the law makes reporting discretionary, it is important to understand the circumstances in which service providers do believe that a case should be reported to authorities. As will be explored in greater depth in section 13, understanding when young people's sexual activity was 'factually consensual' did not appear to be relevant or a priority for service providers, some of whom described all sexual activity of young (unmarried) people as violence and abuse:

Interview, nurse, Batticaloa:

> *Teenage pregnancy is a big problem in our area. Currently we are conducting awareness about teenage pregnancy.*
>
> *Why is there so much teenage pregnancy?*
>
> *It is because of rape – sexual abuse. If people are interested in doing these things they will not listen to us. When something goes wrong we report it to the police.*[68]

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[65] *The question did not specify a time period, so it is possible that the majority of these instances occurred before the government circular was issued in 2010.*

[66] *Individual interview, nurse (II), Colombo, Sri Lanka, 3 November 2015*

[67] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*

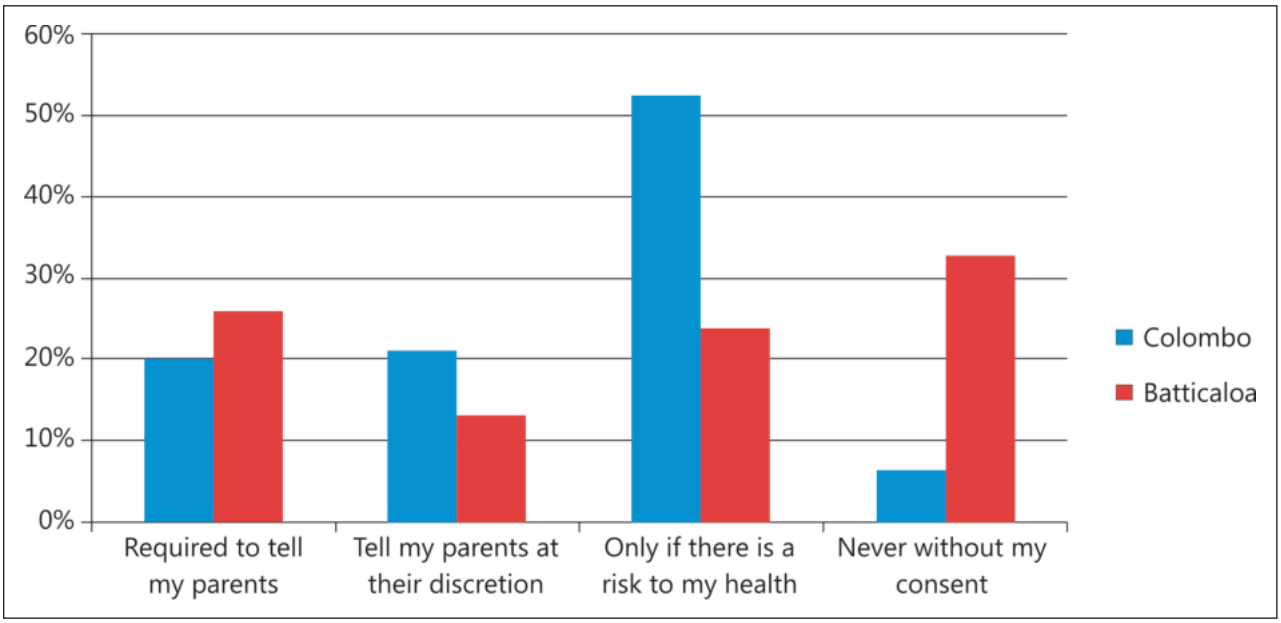
[68] *Individual interview, nurse, Batticaloa, Sri Lanka, 4 November 2015*

As is illustrated by the excerpt above, service providers in Sri Lanka perceived young people's (pre-marital) sexual activity as problematic, sometimes describing it as violence or abuse, regardless of whether it was factually consensual. In the context of this understanding of violence, legal provisions establishing an age of sexual consent are likely to be interpreted first and foremost as being intended to prohibit sexual activity that is socially unacceptable, rather than protecting young people from exploitation or abuse due to their particular vulnerability. As will be demonstrated in the section below, particularly in light of discretionary legal requirements for child protection reporting, this has important implications for when service providers are likely to feel compelled to report a case to authorities, and, perhaps more importantly, when young people expect them to do so.

9.3 Data from young people

Data from the study clearly indicates that children and young people in research sites in Sri Lanka do not consider themselves to have a legal right to confidential access to SRH services, although responses did vary substantially between research sites. Only 6.4% of respondents in Colombo and 32.7% in Batticaloa reported that a doctor could never legally tell their parents without their consent if they accessed contraceptives. As is demonstrated by the charts below, respondents in Batticaloa were slightly more likely to report that rules on confidentiality were absolute than respondents in Colombo were. The majority of respondents in Colombo reported that in law a doctor can only legally inform their parents that they accessed services if there is a risk to their health.

Chart: Can a doctor (legally) tell your parents if you access contraception?



Interestingly, in both research sites, female respondents' perceptions of the law on confidentiality were significantly different from male respondents' perceptions of law, with females more likely to report that service providers were either required to inform a young person's parents if (s) he accessed contraceptives or were able to do so at their discretion, and male respondents more likely to report that confidentiality would be protected, either in all circumstances or unless there was a health risk.[69] This likely stems from the fact that the stigma surrounding sexual activity of (unmarried) young people is greater for girls than boys, who feel more empowered to access services generally and less fearful of the consequences if the fact that they have done so is exposed to their parents / the community: *"boys are the ones who go and*

[69] *Chi-square, p<.01 in Colombo, and p<.05 in Batticaloa.*

buy contraception. Because of our culture girls would be ashamed to do that."[70] Gender differences may also relate to the fact that a young girl's sexual activity is (or is expected to be) more likely to be treated as abuse by service providers and reported to relevant authorities.

Because so few young people in Sri Lanka reported to be accessing services in the first place, data on their experiences and expectations regarding confidentiality when accessing sex-related services in practice was limited. In focus groups discussion and interviews, several young people expressed conflicting views about whether their confidentiality would be protected in practice, emphasising that doctors do respect confidentiality, but acknowledging that if a minor accessed a service at a public hospital they would be referred to child protection authorities:

Focus group discussion, girls, Batticaloa:

> *If you went to ask a doctor's advice on and SRH issue would you feel safe that they would keep that information secret?*
>
> *It won't go out of the office.*
>
> *(The groups agrees) If you tell the doctor it will not go out of the office.*
>
> *But if someone from the community knows it will be shared.*
>
> *What if you are under 18?*
>
> *If it is a private hospital they will not say. In a public hospital they will tell the child protection unit.*[71]

Young people, particularly in Batticaloa, were aware that young people who were found to be sexually active could be reported to child protection and face legal repercussions – *"these children will be placed on probation"*[72]; this is likely to make them feel less secure about the confidentiality of their access to services. Furthermore, several young people did indicate that lack of privacy acts as a barrier to accessing services, particularly in the context of deeply restrictive norms regarding young people's sexuality; "If you request contraceptives from the pharmacy, because of the culture they feel shy"' .

In sum, both qualitative and survey data suggests that young people are uncertain about whether their access to sex-related services will be kept confidential, particularly in light of child protection reporting requirements; a perspective that reflects the ambiguity in the law. Failure to protect young people's access to confidentiality when seeking contraceptive and STI services therefore constitutes a significant barrier to access to services: particularly in an environment where intense stigma exists around youth sexuality.

10. Access to Comprehensive Sexuality Education

Another important barrier to young people's access to SRH in communities in Sri Lanka is the lack of legislation providing for free and universal comprehensive sexuality education. The government of Sri Lanka has articulated intentions to improve adolescent sexual and reproductive health education in its National Strategic Plan on Adolescent Health (2013-2017).[73] One of the strategy's key objectives is to increase the quality and coverage of SRH education for adolescents, though it does not specify from what age. In particular, the strategic plan articulates the goal that 60% of adolescents / young persons have minimum SRH knowledge by 2017.

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[70] *Focus group discussion, young men, Colombo, 2 November 2015*

[71] *Focus group discussion, girls, Batticaloa, Sri Lanka, 5 November 2015*

[72] *Focus groups discussion, boys, Batticaloa, Sri Lanka, 4 November 2015*

[73] *http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/sri_lanka_national_strategic_plan_adolescent_health_2013_2017.pdf*

Despite the fact that a comprehensive sexuality education curriculum is not in place in Sri Lanka, the majority of young people surveyed - 91.5% in Colombo and 60.0% in Batticaloa- reported having received sexual and reproductive health education in school.[74] However data from qualitative interactions suggests that while young people do receive some information that is relevant to sex and reproduction in school, their education is limited to very basic descriptive information explaining biological functions associated with puberty and the science of reproduction. As a group of boys in Colombo explained, *"We don't receive very much [information]… in school we learn about the health, how a girl and boy age, about how puberty will affect them. We speak about it among friends – some do not use the word 'sex'"*.[75]

Indeed, focus group discussions with young people demonstrated the degree to which young people (and even parents) are extremely poorly informed about important issues in relation to sexuality, reproduction and health. In several focus group discussions one or more participants hadn't heard about contraceptives, as in the following focus group discussion with young adults in Batticaloa:

Focus group discussion, young people (mixed), Batticaloa:

If a couple gets married in your community, but they don't want to have kids right away, is there anything they can do to prevent pregnancy?

We do not know about that. (I push them on this.) Seriously, we do not know.[76]

In other cases, young people held serious myths and misconceptions about sexual and reproductive health, and, in particular about methods for contraception. Consider the following interaction with a focus group of young boys in Batticaloa:

Focus group discussion, boys, Batticaloa

What about condoms, can you get those?

I've never heard of those.

[One boy covers his face].

There are some side effects…to condoms.

What sort of side effects?

Like HIV. They can cause HIV. And infertility…

What do you know about STIs?

[Silence].

There is anemia…HIV…

How do you get an STI?

No one has ever taught us about that.

Have you ever had any SRE?

We only learn about that through the media – mainly the TV and the news.

If we go to communal places, like public meetings about health, people talk about those things and give advice.

Sometimes women get advice from the clinic level.

In Islamic stories these topics are mentioned – in the Koran.[77]

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[74] *It is also important to note that, given that survey respondents were largely accessed through schools and service providers, the sample of young people surveyed in Sri Lanka is likely to over represent young people who are receiving SRE.*

[75] *Focus group discussion, young men, Colombo, 2 November 2015*

[76] *Focus group discussion, parents (mixed), Batticaloa, Sri Lanka, 4 November 2015*

[77] *Focus group discussion, boys, Batticaloa, Sri Lanka, 5 November 2015*

Not only does lack of access to sexuality education impede upon young people's sexual and reproductive health, and in particular their ability to make decisions about how to have a healthy and safe sexual life; lack of knowledge and information acts as an important barrier to young people's service seeking behaviour. Indeed, the research clearly evidenced that lack of comprehensive sexuality education is a significant barrier to accessing SRH services, as in the following case of a group of young women from Batticaloa:

Focus group discussion, young women, Batticaloa

> *I have a question for the girls in the group – has anyone taught you about family planning?*
>
> *No one has taught us.*
>
> *Do you know where you could go to get contraceptives?*
>
> *No.*[78]

Many service providers attributed young people's lack of access to the services they need to a dearth of knowledge and information:

Interview, Doctor, Colombo:

> *In your experience, how well informed are young people about sexual and reproductive health?*
>
> *Some young people have good SRH – those that take higher education. Those with less education do not have it. There is a problem with teenage pregnancy because of lack of education. We have many unmarried girls who are pregnant because they are not using contraceptives.*[79]

Interview, Doctor, Colombo:

Do you think young people have access to the SRH services they need, and if not, what could be done to improve on this?

There is no barrier to young people accessing services. We don't see them [at the clinics] but maybe that's because they are not aware. They are shy. They have no proper knowledge about these things, and they don't know where to go. We need more awareness, more lectures, more education. We have to guide them. We have to teach them. We have to give the school children proper knowledge.[80]

Yet while the need for improved sexuality education in Sri Lanka is clear, it is a socially controversial issue. Several service providers pointed out the difficulty of implementing sexuality education in communities where parents, teachers and other authorities are resistant to providing children with information for fear that it will encourage them to become sexually active at an earlier age. As one service provider in Batticaloa explained, *'We have a programme with pamphlets with messages that the district health programme provides in schools. It needs to be expanded…but it is not welcome in schools, especially in the Muslim area – this is a barrier for us as we are not very open when we do education. Teachers do not like that. They protest that children will be spoiled.'*[81]

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[78] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

[79] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*

[80] *Individual interview, doctor, Colombo, Sri Lanka, 2 November 2015*

[81] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

The resistance reflects a dominant narrative that appeared to be prevalent across research sites, according to which restricting young people from accessing information is an effective strategy for preventing them from engaging in sex at a young age or before marriage. Yet, as pointed out by the following group of young women in Batticaloa, rather than preventing pre-marital sex, without access to education and information, young people are more likely to engage in unprotected sex that results in unwanted pregnancy:

Focus group discussion, young women, Batticaloa

> *[In reference to a girl who had an unwanted pregnancy]: They should have used family planning, but they did not know about it so they did not get it – in schools there is no awareness about these issues.*
>
> *Why do you think that is?*
>
> *Right now it is still because of parents…but now there is an increase in rape and violence so that is why they teach them about family planning.*[82]

The girls in the focus group explain that while parents are resistant to the idea of sexuality education in schools, educating young people about sex is considered to be more acceptable in the context of increasing levels of *'rape and violence'*. This characterisation is revealing; increasing sexuality education for young people can be justified as necessary in order to prevent rape and violence, which is unambiguously unacceptable sexual behaviour. Again, their response appears to reflect narratives according to which all sexual activity outside of marriage is considered to be abuse. This approach to CSE, whereby young people are educated in order to 'protect themselves' from socially inappropriate sexual encounters, is problematic, as it conflates young people's decisions about whether to have sex at all, with their decisions about how to stay sexually safe and healthy. Such an approach unlikely to provide with the information and tools to understand their developing sexuality, make informed decisions, and access the services they need to protect their health.

The research findings, therefore, indicate that the lack of legal guidance in Sri Lanka, mandating, objective and value-neutral comprehensive sexuality education in schools, is creating a barrier to access to education for young people in practice, as well as to SRH services more broadly.

11. Access to Abortion

11.1 General legal restrictions on access to abortion

The law in Sri Lanka creates significant direct legal barriers to access to abortion services, which affect all women in Sri Lanka, but are likely to have a disproportionate impact on young women and girls. Under the Penal Code of 1883, abortion is only permitted to save the life of the woman.

Section 303 of the Penal Code establishes that 'causing a woman to miscarry' is illegal and subject to up to three years' imprisonment and/or payment of a fine. If the woman is "quick with child"[83] causing a miscarriage is subject to imprisonment up to 7 years, and with a fine. Section 306, further states that any act preventing a child to be born alive or causing a child to die after its birth is punishable with imprisonment of up to 10 years.[84] Finally, causing a miscarriage without a woman's consent is subject to

[82] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

[83] *Interpreted as the later stages of pregnancy.*

[84] *Penal Code 1883 s 306.*

punishment with imprisonment for a term, which may extend to 20 years and a fine. The same Section of the Code also makes clear that these provisions would also apply to a woman who causes her own miscarriage. The only exception provided by the legislation is if the miscarriage was caused "in good faith", in order to save the life of the mother.[85] Further, there are no provisions in the Code regarding who may perform an abortion or regarding the facilities where abortions may be undertaken.

According to a WHO report in 2013, legal abortion services where there is a clear medical indication to save the life of the woman are available at government hospitals that have specialised maternity and gynaecology units and are free of charge when certified by two obstetricians/gynaecologists and/or a psychiatrist.[86] However, there are no national standards and guidelines around abortions in Sri Lanka.[87] According to the same report, only gynaecologists who are certified by a board can provide abortion services.[88]

In addition, according to information from 2012, neither mifepristone nor misoprostol - the two drugs which are highly effective in combination for medical abortion - are registered[89] for use in medical abortions in Sri Lanka.[90] This limits the options for women who do qualify for legal abortion to surgical procedures only, and further to where these procedures are available.[91]

The law in Sri Lanka does not specifically impose reporting requirements on service providers who suspect that a woman has undergone an illegal abortion. According to Asia Safe Abortion Partnership (ASAP) ASIA, post abortion care is freely available in public and private hospitals as part of primary health care. According to ASAP, in practice, no legal actions are taken against women who identify themselves as having undergone an illegal abortion, and health providers do not need to report cases to authorities should they find out, or suspect, that a woman has undergone an abortion "illegally".[92] Thus, in theory, women should be able to seek essential medical services post-abortion freely even in cases where they have undergone an abortion illegally; nevertheless, women may be afraid to do so in practice due to fear of prosecution, and stigma associated with abortion reinforced by criminalisation under the law.

11.2 Perceptions and knowledge of law: adolescents and young people's access to abortion

Abortion appears to be one of the areas where the law regulating access to SRH services was most familiar to respondents: all respondents interviewed in the qualitative research were aware that there are general legal prohibitions on abortion in Sri Lanka. The majority of services providers in the qualitative research, 5 out of 7 interviewed, correctly noted that abortion is generally illegal and were aware of the exception where it is necessary to save the life of the mother. The remaining 2 service providers believed abortion to be illegal in all circumstances.

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[85] *Penal Code 1883 s 303.*

[86] *WHO, Mapping abortion policies, programmes and services in the South-East Asia Region (New Delhi: World Health Organization, Regional Office for South-East Asia, 2013), p. 18, accessed 14th October 2015. http://apps.searo.who.int/PDS_DOCS/B5034.pdf*

[87] *WHO, Mapping abortion policies, programmes and services in the South-East Asia Region (New Delhi: World Health Organization, Regional Office for South-East Asia, 2013), p. 18, accessed 14th October 2015. http://apps.searo.who.int/PDS_DOCS/B5034.pdf*

[88] *WHO, Mapping abortion policies, programmes and services in the South-east Asia Region, (New Delhi: World Health Organization, Regional Office for South-East Asia, 2013), p. 18, accessed 14th October 2015. http://apps.searo.who.int/PDS_DOCS/B5034.pdf*

[89] *Registration is the process by which a drug is approved by a regulatory agency for importation, distribution and marketing for a specific medical usage.*

[90] *Ramya Kumar, "Misoprostol and the politics of abortion in Sri Lanka", Reproductive Health Matters 2012;20(40):166–174, accessed 22 October 2015 http://www.rhm-elsevier.com/article/S0968-8080(12)40652-8/pdf.*

[91] *Ramya Kumar, "Misoprostol and the politics of abortion in Sri Lanka", Reproductive Health Matters 2012;20(40):166–174, accessed 22 October 2015 http://www.rhm-elsevier.com/article/S0968-8080(12)40652-8/pdf.*

[92] *ASAP (Asia Safe Abortion Partnership) "Country Profile – Sri Lanka" accessed 14th October 2014.http://asap-asia.org/country-profile-sri-lanka/.*

Young people and parents on the other hand seemed to have very limited knowledge of the specifics of legal provisions concerning abortion: most young people in the qualitative research emphasised simply that abortion is both illegal, and unacceptable according to social and religious norms. Survey data revealed similar results. While nearly all young people surveyed recognised that there are legal restrictions on abortion for young people, only **22.9%** of young people in the survey correctly identified that a minor would be allowed legal access to abortion but only in a case where the abortion was necessary to save the life of the woman/ girl. An even larger proportion of young people **33.9%** reported the view that abortion was illegal for a minor in all circumstances, without exception. Respondents in Batticaloa (**36.6%**) were particularly likely to perceive there to be an absolute prohibition on abortion. Female respondents were more likely than male respondents to perceive there to be an absolute prohibition on abortion in all circumstances: as many as **40.9%** of female respondents (compared to **29.2%** of male respondents) held this view.[93] These results may be the consequence of discriminatory gender identities and roles, which designate 'motherhood' as the primary goal of female personhood; with female sexuality confined to a means to realising this end. The law appears to be broadly consistent with, and may also serve to solidify, dominant social and religious norms on abortion, which respondents themselves tended to endorse. In addition to identifying legal prohibitions on abortion, respondents described abortion as sinful and socially/culturally unacceptable: *"abortion is a sin";*[94] *"society is not allowing abortion;"*[95] *"this is a murder case, it is a crime, our culture is not to allow abortions"*[96] were typical remarks made by participants.

11.3 Influence of law: restrictions on access to abortion

The almost absolute prohibition on abortion in Sri Lanka evidently has a direct and severe impact on a young woman's ability to access abortion in the case that she becomes pregnant. However, there may also be a wider affect: criminalisation of abortion may serve to solidify the taboos and shame associated with sexual activity amongst young people, particularly in a context where having a baby outside of marriage is so deeply stigmatised. One group of young people explained the dilemma that a young girl in this situation would face: *"now the pregnancy has happened. She cannot get an abortion. She will have to proceed with the pregnancy. [But] society doesn't allow that [an unmarried girl to deliver a baby]. Society won't accept the girl. She will have to go far away to another area."*[97]

As the previous passage demonstrates, a girl who becomes pregnant outside of marriage is left in a precarious and vulnerable position: it is neither socially acceptable for her to terminate her pregnancy, or to deliver the baby. In such a context, respondents concluded that a girl's only two options would be marriage or suicide:

> *"She will be forced to get married. She may do suicide. [But] it is not appropriate to have an abortion. It's not right to kill another human being".*[98]

> *"If you are pregnant you get respect within the community only by marrying the person. [Otherwise] the community will ostracise the mother and the child if they are not married."*[99]

[93] *Chi-square, p<.1*

[94] *Focus group discussion, mothers, Batticaloa, Sri Lanka, 5 November 2015*

[95] *Focus group discussion, young people (mixed), Batticaloa, Sri Lanka, 4 November 2015*

[96] *Focus group discussion, mothers, Colombo, Sri Lanka, 3 November 2015*

[97] *Focus group discussion, young people (mixed), Batticaloa, Sri Lanka, 4 November 2015*

[98] *Focus group discussion, young men, Colombo, 2 November 2015*

[99] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

The quotes above demonstrates the intensity of the shame and social rejection that a young girl would undergo if she became pregnant outside of marriage, which, as previously discussed, many young people invoked to explain why it is wrong for a young girl to have sex before she is married. By contributing to the stigma surrounding pre-marital sex, the abortion ban may serve to intensify barriers young girls face accessing other SRH services (services that, ironically, could help avoid an unplanned pregnancy in the first place).

The difficulties associated with pregnancy outside of marriage in a context where abortion is illegal, may intersect with other forms of disadvantage to place some young women in acutely vulnerable situations. A group of young women accessed at a residential school for people with disabilities explained:

> *"[if a girl gets pregnant] she will be ashamed. She will keep the baby, but it will be a challenge. She is disabled. She will be unable to walk. She will be unable to get a job, and she is in an illegal marriage. It will be very difficult for her to survive. Because of her disability she will not be capable of carrying a baby – her parents can take the baby or donate it to an orphanage".*[100]

And a group of disabled boys at the same centre told researchers:

> *"[if a girl gets pregnant before marriage] she will be blamed by the society. In an incident of this in our [the disabled] community the girl committed suicide. This should not have happened. Ideally she should have spoken to her parents and married the boy".*[101]

Respondents' ideas about the problems associated with pregnancy outside of marriage, as well as abortion, were often tied up in narratives about the body, and the idea that early pregnancy, and abortion are harmful to a young girls' health; these ideas appear to be anchored in dominant ideas about 'childhood', which designate childhood as a period of sexual and reproductive immaturity, underdevelopment and 'innocence'. [102] As a group of young men in Batticaloa articulated:

"The baby could be affected by poor health. The baby could get malnutrition. The mother and the baby will get no respect from society… Having a baby too young is like building a castle in the beach sand. If you build a castle in the sand – no one can live in it. It can get destroyed in the rain. According to Islamic law we will throw stones at a women/ girl who has a baby outside of marriage."[103] Indeed, when explaining what is wrong with abortion and why, respondents often focused on the health risks associated with abortion, sometimes using this as a justification for why abortion is and should be illegal: *"there is no need to make that legal. If it is legal then mothers will do that always. It is dangerous. Many of these mothers already have children and the children will miss their mother if she dies during abortion."*[104] *However, it is the highly restrictive conditions for access to legal abortion in Sri Lanka that require women to seek services outside of the official health care system with significant risks to their health; as one respondent argued: "we need to change the law on abortion, because otherwise young women will go to underground places and lose their lives."*[105]

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[100] *Focus group discussion, girls with disabilities, Colombo, Sri Lanka, 3 November 2015*

[101] *Focus group discussion, boys with disabilities, Colombo, 2 November 2015*

[102] *Yarrow, E. et al., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014.*

[103] *Focus group discussion, young men, Batticaloa, Sri Lanka, 5 November 2015*

[104] *Individual interview, doctor, Colombo, Sri Lanka, 3 November 2015*

[105] *Individual interview, nurse, Batticaloa, Sri Lanka, 4 November 2015*

Indeed the impact of the abortion ban in Sri Lanka appears to be severe. Data collected by UNFPA in 2006 and 2007 found that maternal deaths due to unsafe abortion was the fourth leading cause of maternal deaths in Sri Lanka, accounting for 12.33% and 10.64% of all maternal deaths respectively during those years.[106] One woman interviewed in Colombo described her experience trying to access an 'abortion' illegally:

> *"In my second pregnancy I tried to do an abortion and I asked some elders and they gave them things to eat… I wanted to escape the baby because my husband is doing drugs and has no earnings. I had a lot of delivery pains because of what I ate – I ate a lot of things (to try) to stop the pregnancy. So I tell girls not to do an abortion because of my experience – my baby is 2 years. My punishment for trying the abortion is to carry the pain for one year. My fallopian tubes on my rights side are damaged from the abortion."*[107]

12. Access and privilege: private vs. public clinics

Access to services is also an issue of privilege, and this is most particularly the case for children and young people. In qualitative interactions young people explained that money pays a major role in determining whether children under the age of 18 years will be able to access SRH services: *'Even if we consult with a doctor – before we are married they will not give us those pills. In the pharmacies you can get them but people might arrest you. But some people might decide that they make good money so they will sell it to you!'*[108]

Many respondents drew distinctions between the barriers young people experience when accessing services in public clinics, where services are free, and those they experience in private clinics, which require fees. Services at private clinics were described to be superior and a greater number of services were thought to be available: '*Some of the public clinics do not have choices (like the implant) and so women will go to the private clinics… in the private sector you may pay up to 10,000.00 rupees…*'[109] Several respondents were under the impression that abortion, including medical abortion, are accessible in private clinics:

Focus group discussion, mothers, Colombo:

> *If a girl is not married and gets pregnant what are her options? …Is abortion an option for her?*
>
> *Some in the private sector may do it – not in the public sector. Using abortion tablets…*[110]

Several respondents also expressed the view that in a public clinic their access to services would not be kept confidential, but in a private clinic they could access services confidentially. Whether or not this is true in practice, the fact that young people perceive it to be true may create barriers for young people who cannot afford private services from accessing public clinics;

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[106] *Ramya Kumar, "Abortion in Sri Lanka: The Double Standard" Am J Public Health. 2013 March; 103(3): 400–404, accessed 20th October 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673519/. And Ernest and Young & IPPF, SRH Policy and Programme Analysis Sri Lanka, 2012, p. 8.(Provided by IPPF)*

[107] *Focus group discussion, mothers, Colombo, Sri Lanka, 3 November 2015*

[108] *Focus group discussion, boys, Batticaloa, Sri Lanka, 5 November 2015*

[109] *Focus group discussion, mothers, Colombo, Sri Lanka, 3 November 2015*

[110] *Focus group discussion, mothers, Colombo, Sri Lanka, 3 November 2015*

Focus group discussion, young women, Batticaloa:

> *If you went to ask a doctor's advice on an SRH issue would you feel safe that they would keep that information secret? What about if you are under 18?*
>
> *If it is a private hospital they will not say. In a public hospital they will tell the child protection unit.*[111]

Private clinics may also be more accessible to young people because they are more anonymous than public clinics. As one service provider explained, public health services in Sri Lanka are connected to place of residence. Given the intensity of stigma surrounding youth sexuality and, as an extension of this, access to contraceptive services, young people are much more likely to access services outside of their community in an anonymous environment where they feel safe that their access will be private:

Nurse, municipal council clinic, Colombo:

> *Young people do not come to access services here...they report to the private sector.*
>
> *Why do young people go to the private sector but not do this clinic?*
>
> *This is a government clinic that is established in the area. We are established in the village – we serve the village. Young people can go to any private clinic anywhere in the country, but they can't go to a government clinic. They have to go to a government clinic in their own area.*[112]

Interestingly, survey data appears to reflect the fact that access to financial resources facilitates young people's access to services: respondents to the survey with higher wealth scores were less likely to have been denied access to a service than respondents with lower wealth scores, even when controlling for a young person's gender, age and marital status.

While laws apply in the same way to private and public clinics, it seems plausible that the more restrictive approach taken by public clinics may be related to the fact that they are run by the government, and are less independent from institutional constraints and political and social norms and influences. The more 'open' culture in private clinics may also result from the fact that they are accessed by clients from more privileged backgrounds, who are less likely to identify with 'traditional' or socially conservative identities associated with restrictive narratives regarding young people's sexuality.

Sex, Violence and the Law

Limited legal definitions of sexual violence, and the failure in law to protect individuals from sexual and gender based violence in all contexts, creates barriers to access to SRH services for those survivors who are not protected in law. On the one hand limited legal definitions exclude some survivors from being eligible for support services; on the other hand, survivors of violence may be less likely to recognise violence when it occurs, and to identify themselves as having been subject to abuse. In circumstances where survivors would like to access help and support, they may fear that their claims will be viewed as lacking legitimacy and justification.

[111] *Focus group discussion, young women, Batticaloa, Sri Lanka, 5 November 2015*

[112] *Individual interview, nurse (female), municipal council clinic, Colombo, Sri Lanka, 2 November 2015*

13. Limitations in law and its implementation

13.1 Rape of men/boys and third gender individuals

In Sri Lanka rape is defined as "sexual intercourse with a woman", thus, the definition of rape is gender specific and limited to heterosexual interactions. However, Section 365 (b) of the Sri Lankan Penal Code also criminalises "grave sexual abuse" which is defined as: *"any act, by the use of his genitals or any other part of the human body or any instrument on any orifice or part of the body of any other person, being an act which does not amount to rape"* which protects male and third gender individuals as victims of sexual violence, even though this is not defined as 'rape' within the law, and penalties for the crime of "grave sexual abuse" is lesser than that of rape, providing a lower level of protection.

13.2 Evidentiary standards of rape

Importantly, Section 363 of the Sri Lankan Penal Code provides that evidence of resistance (of rape) is not needed to prove that sex was non-consensual. Jurisprudence, however, has limited this provision. In the case of Kamal Addararatchi v. State the Supreme Court upheld a ruling that victims of rape must show evidence of struggle to prove a lack of consent. As the survivor sustained no demonstrable injuries, the Supreme Court found that she had consented to the sexual act.[113] This interpretation of rape law is likely to have a detrimental impact on service seeking behaviour for survivors of sexual violence, as survivors may believe that they cannot seek assistance if they will be unable to prove that they were raped.

13.3 Rape within marriage

Critically, penal law contains an exception for the crime of rape, where forced sexual activity takes place in the context of marriage. Section 363A of the Sri Lankan Penal Code provides that a married woman will only be considered to have been raped by her husband if she is judicially separated from him. Further, as set out in section 8, penal laws in Sri Lanka establish a lower age of sexual consent for girls who are married. Thus a married girl or woman will can never be considered to be raped by her husband as per the law unless she is under 12 years of age.

Allowing for marital rape within the law constitutes a direct violation of the sexual and reproductive rights of women and girls. In addition, these laws are liable to have significant consequences for access to SRH services. In the cases where their husband is the perpetrator, survivors of sexual violence may not consider themselves eligible to access services, and practitioners may be less likely to support survivors, and provide services, where the survivor is married.

13.4 Statutory Rape

As discussed, the Sri Lankan Penal Code established the age of sexual consent in Sri Lanka to be 16 years for both males and females. This law purports to protect children from sexual abuse and exploitation; it acknowledges that children's age, lack of experience, heightened impressionability and subordinate social status, places them in a position of relative powerlessness which renders them especially vulnerable to grooming and exploitation by others. In such a context, establishing a minimum age of sexual consent in law protects children who may have ostensibly 'agreed to sexual activity; but did so through manipulation, or without their full understanding.

[113] *One billion rising for justice "Current legal framework: Rape and Sexual Assault in Sri Lanka", 23 August 2013, accessed 13th October 2015. https://obrsrilanka.wordpress.com/2013/08/22/current-legal-framework-rape-and-sexual-assault-in-sri-lanka/.*

Notwithstanding the legitimate protective purpose of these laws, and has been discussed through this report, the establishment of a minimum age of sexual consent in law also serves as a mechanism for regulating children and young people's sexual identities and behaviour. Unfortunately, evidence from the data has shown that the law is typically applied with the latter function in mind, reflecting the fact that (as discussed in section 8) statutory rape laws are largely enforced to compel children into marriage, or in circumstances where the parents of a couple object to the nature of their relationship. In its most extreme expression/manifestation, girls who engaged in (factually consensual) pre-marital sex appear to have been placed in a child protection facility for their own protection from 'statutory rape', until they are old enough to legally marry, and their engagement in a sexual relationship is considered to be acceptable.

13.5 Providing and accessing SGBV services in practice

While **46.4%** of service providers surveyed in Sri Lanka reported to offer SGBV related services, indicating that these services are available, service providers interviewed for the study emphasised that they rarely provide SGBV related services in practice because survivors do not come to access them. For instance, when asked whether she had treated patients who were survivors of sexual violence, a nurse in Colombo explained: *"this will be discussed only with the husband and wife…usually people do not tell the service providers of any incident of sexual violence because they are too shy. They are afraid of their husbands. Sometime they are not aware that is sexual violence".*[114] *Similarly, a second service provider told researchers: "maybe clients are hiding [experiences of sexual violence]… here the community is closed to each other. People will think that this person has engaged in some bad sexual behaviour or something like that."*[115]

The nurse and doctor quoted above give several explanations for survivors' reluctance to report SGBV: social norms which dictate that problems within a marriage should be resolved within a household; general acceptance and normalisation of violence within marriage – 'sometimes they are not aware that is sexual violence'; and shame and humiliation associated with having experienced violence.

Indeed, no female survey respondents reported having been forced into sex, and the only one male survey respondent who reported to have been forced into sex did not report having accessed SGBV-related services.[116] These figures are likely indicative of the degree to which social and cultural barriers prevent all young people, and particularly women and girls from both reporting experiences of SGBV and from accessing SGBV services.

Service providers emphasised that barriers to reporting and addressing cases of sexual violence are not a problem of Sri Lankan law; "There are laws on this, action can be taken – but people do not take action. The law is there. There is no problem with the law. It's an education thing..."[117] Participants in the qualitative research demonstrated an awareness that sexual and domestic violence are prohibited by the law, yet notably no respondents described a scenario (hypothetical or real) in which a man would be held legally accountable for physically or sexually abusing his wife. Instead, they suggested that the police would play a mediating or advisory role, providing constructive solutions to the couple in order to address the violence:

[114] *Individual interview, FPAI counsellor, Batticaloa, Sri Lanka, 2 November 2015*

[115] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*

[116] *18 female respondents and 12 male respondents selected the option 'I prefer not to say', rather than answering 'no' to the question. Of the 18 female respondents, only 1 reported to have accessed an SGBV service. Of the 12 male respondents, 4 reported to have accessed an SGBV service.*

[117] *Individual interview, FPAI counsellor, Batticaloa, Sri Lanka, 2 November 2015*

Focus group discussion, young men, Colombo:

How do you think the health worker or police would treat the girl if she reported the rape?

If the girls inform the police they will ask the husband to come to the police station. They will advise the husband not to do this… The law says you can get the death penalty for rape – there are several laws on this.[118]

Focus group discussion, young women, Batticaloa:

> *Are there any circumstances in which a woman could report her husband to the police?*
>
> *If he is beating her very badly.*
>
> *How would the police react?*
>
> *They would ask you to come back with your husband. They will sit down with your husband and ask him whether he will do it again. He will say 'I will not do it again' and the police will send you back home.*[119]

This apparent impunity for SGBV committed within marriage is consistent with the law in Sri Lanka, which fails to criminalise sexual violence within marriage, including for girls as young as 13. Indeed, married women interviewed for the study described divorce as the most severe, final solution to be applied if violence (including sexual violence) did not stop, but did not appear to see criminal prosecution of a violent husband as a possibility:

Focus group discussion, women, Colombo:

> *Are there any circumstances in which a woman could report her husband to the police?*
>
> *If he is beating you very badly.*
>
> *How would the police react?*
>
> *They would ask you to come back with your husband… They will sit down with your husband and ask them whether they will do it again. He will say 'I will not do it again' and the police will send you back home.*[120]

Attitudes that hold women and girls responsible for their own experiences of abuse were found to act as an important barrier to young people's ability to report and access services for SGBV. These attitudes were articulated by respondents across research sites, including young people. Consider the following interaction with a group of boys in Batticaloa:

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[118] *Focus group discussion, young men, Colombo, 2 November 2015*

[119] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

[120] *Focus group discussion, young women, Batticaloa, Sri Lanka, 4 November, 2015*

Focus group discussion, boys, Batticaloa:

Imagine that your sister comes to you one day and tells you that a boy has forced her to have sex with him – how would you react?

We would beat her too (in addition to the boy). At that age she should study. Only by beating and punishing her can we make sure she will not act like that again.

But what if he forced her?

It is an offence, but I am unable to go to the police station.

Why?

Because even my sister is in the wrong. We cannot go to the police or to the courts. Everyone would lose respect for the family. We should solve this case between the two families and get them married. She has to marry him. That same person. That is the rule in the Tamil culture.[121]

As demonstrated by the interaction above, impunity for male perpetrators of sexual violence is likely to occur in a context where a woman or girl is considered to be responsible for her own abuse: *"It is an offence, but I am unable to go to the police station…because my sister is in the wrong."* As demonstrated by the excerpt above, respondents explained that a woman or girl who has been subject to sexual violence is not only liable to bring shame and humiliation on herself as an individual; she may also undermine the honour of her entire family. These attitudes appear to consider a girl or woman's consent to sexual activity as entirely irrelevant, holding her responsible for sexual transgression regardless. They are consistent with dominant norms explored in section 8 of this report, according to which all sexual activity outside of marriage is considered to be abuse and no sexual activity within marriage is considered to be abuse.

The harmful impact and absurdity of such norms may particularly affect younger women and girls under the authority of their parents, particularly if they are not yet married, and have thus transgressed social norms prohibiting pre-marital sex. This is demonstrated by the exchange below:

Focus group discussion, boys, Batticaloa:

Do you have any recommendations for improving young people's access to SRH services?

Don't be like that girl in Jafna [referring to an earlier mentioned case of gang rape]. The girl was called Seema and she was infected. Don't do things like this, or become like these two victims. You will become a victim of child abuse. We learned from the media about the punishment for this. We could get life-long jail. According to Islam the offender should be punished to death by throwing stones. Even if the person involved in those activities escaped the law, they will be shunned by society.

If you had sex with a girl your age – and you both consented – would you get this punishment?

Yes. Both of us will get this punishment. We will get lifelong imprisonment.[122]

[120] *Focus group discussion, boys, Batticaloa, Sri Lanka, 4 November, 2015*

[121] *Focus group discussion, boys, Batticaloa, 5th November, 2015*

[122] *Focus group discussion, boys, Batticaloa, 5th November, 2015*

Law, Heteronormativity and LGBTI Individuals

One of the most important ways in which law may impact on young people's access to services, is through the regulation of young people's gender and sexual identifies and behaviours. Individuals who fail to conform to dominant categories established in law, or who directly violate provisions that criminalise certain sexual identities and behaviours, are likely to face significant barriers to access to services, either because they fear prosecution, or because the government services fail to contemplate and provide for their needs.

14. Law that regulates sex and sexuality

14.1 Criminalisation of LGBT Individuals

Section 365(a) of the Sri Lankan Penal Code provides that: "gross indecency" between two persons is criminalised and punishable with imprisonment of up to two years or with a fine, or both, under the Penal Code (Amendment) Act 1995, section 365 (a).

Although no further explanation of what constitutes "gross indecency" is provided in the law, this provision is generally understood to apply to same-sex sexual activity. While there have been no convictions under sections365 and 365A since Sri Lanka gained independence in 1948[123], the lack of clear definition of the term "gross indecency" is further, in itself, problematic as it leaves the law open to inconsistent implementation and potentially to misuse: as will be discussed below, many respondents perceived same-sex sexual activity to be illegal. Through an amendment of the Act in 1995 the word "males" was changed to "persons" thereby extending the provision to people of any gender.

Section 365 further provides that:

> *"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman, or animal, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be punished with fine."*[124]

Under both section 365 and 365A, where the offence is committed by a person over 18 years of age in respect of any person under 16 years of age, this will amount to a stronger punishment, of not less than 10 years and not exceeding 20 years and with a fine as well as a payment of compensation of an amount determined by court.[125]

In addition to the criminalisation of same sex sexual activity, provisions in the Penal Code have been used to prosecute transgendered people: Section 399 of the Penal Code makes it an offence to cheat the public by impersonation, and provides that whoever is convicted of this offence will have to face a punishment of imprisonment for a term which may extend to 3 years, or with fine or with both.

According to a recent shadow report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), this provision in the penal code has previously be used to 'charge women or men who do not conform to gender norms' who have been arrested for 'misleading the public'.[126]

The legality of sex reassignment surgery in Sri Lanka is unclear as no comprehensive national policy or guidelines exist.

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[123] *Equal Ground, 'Human Rights Violations Against Lesbian, Gay, Bisexual, and Transgender (LGBT) People in Sri Lanka: A Shadow Report', http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/LKA/INT_CCPR_ICO_LKA_15986_E.pdf*

[124] *Penal Code Amendment Act 1995 s 365 (a) and s 365.*

[125] *Penal Code Amendment Act 1995 s 365 (a) and s 365.*

[126] *Kaleidoscope, Shadow Report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), September 2014, p. 5, accessed 20th October 2015. http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/09/Sri-Lanka-Report-Final.pdf*

14.2 Perceptions of law

Despite the fact that legal provisions criminalising same sex sexual activity are no longer implemented in practice, many young people included in the study held the belief that both same-sex sexual activity and sex reassignment are illegal:

Focus group discussion, young men, Batticaloa:

> It is illegal for a boy to have sex with another boy. They will be taken to the police station…To change your gender is [also] not acceptable. It is not legal. According to Islam is not good to change the sexual organs that god has created.[127]

Focus group discussion, boys, Batticaloa:

> *Is there a law about being gay?*
>
> *It's available in other countries but not here in Sri Lanka. Here you will be arrested.*[128]

Problematically, these views were also held by MSM and transgender persons themselves, many of whom were aware of the specific criminal provisions in the law, and believed them to be in force:

Focus group discussion, transgender and MSM community, Colombo:

> *Are there any laws in relation to being gay, transgender or bi-sexual?*
>
> *Whatever the sexual activity – between two men – it is prohibited.*
>
> *Why do you think that is?*
>
> *It's in the constitution. It is unacceptable sexual behaviour. It has been written.*
>
> *It is considered to be abnormal behaviour.*[129]

The fact that the MSM and transgender community is aware of the 'unnatural offences' provision and believes it to be in effect demonstrates that the law is interpreted as discriminating against MSM and LGBTI persons and highlights the importance of removing the provisions. Furthermore, as the following paragraphs demonstrate, the (perceived) criminalisation of same-sex sexual activity functions to create significant barriers to access to services for these groups in practice.

14.3 Impacts of criminalisation: access to services

Criminalisation under the law reinforces the stigma associated with sexual and gender behaviours and identities that do not conform to dominant social norms. Individuals who engage in criminal sexual acts may live in constant fear of the potential threat of arrest and prosecution and may be unwilling to reveal to others - including service providers - that they have engaged in same-sex sexual activity; this has implications for their health treatment and care in relation to SRH.

LGBT individuals are likely to experience feelings of shame about their sexuality and/ or gender identity that may make them less confident in seeking out SRH services, and they may be concerned about facing

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[127] *Focus group discussion, young men, Batticaloa, 5 November 2015*

[128] *Focus group discussion, boys, Batticaloa, 5 November 2015*

[129] *Focus group discussion, young transgender and MSM community, Colombo, 2nd November 2015*

ill-treatment or discrimination by service providers if and when they do so. [130]They may also fear that seeking services could lead to their sexuality or sexual activities being exposed to parents/ guardians, other relatives, and/or the wider community.

LGBT individuals interviewed in the qualitative research spoke of the difficulties that they experience accessing SRH services:

> *"The first thing we feel [when going to a health service] is fear. According to the law what we are doing is banned – so we would be afraid. So there is no reason to go along. As an individual we will not go to access. We might go and say that we had sex with a woman and that is why we are getting and HIV test, but we will never say that we had sex with [another] man."*[131]

These findings were supported by evidence from FGDs with other groups of young people who, in general, expressed very limited understanding of issues related to sexuality and LGBT identity, and spoke in discriminatory and judgemental ways about such groups, and underscored the exclusion and rejected that they are likely to face from broader society:

> *"Being gay is wrong because HIV can be spread."*[132]

> *"If I saw a gay or transgender person I would take that boy to a girl and fix that relationship. They should get rid of that attraction to other boys and focus on women. God has created us like that. The female has an organ – it is easy to have sex with a woman. If a man has sex with another man he will die – it causes child abuse."*[133]

> *"Those people get bullied by society. They will feel ashamed".*[134]

Criminalisation of same-sex sexual activity also has an impact both on information and education provided around sexual and reproductive health as well as on what services are provided within the public health services and how these cater (or do not cater) for a diversity of sexual and gender preferences and identities. Information on SRH issues is biased and discriminatory against individuals who do not conform to dominant ideas about sexuality and gender norms, and may include misinformation and inaccuracies. Furthermore, the ability of health providers to provide services in line with these group's specific needs is not readily available.[135] As a result, these persons may not choose to engage with the public health care system because their needs are not being met.

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[130] *Kajal Bhardwaj and Vivek Divan, Sexual health and human rights: A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand, p. 47, (Geneva: World Health Organisation, 2011) accessed 3rd November 2015 http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf*

[131] *Focus group discussion, MSM and TG community, Colombo, Sri Lanka, 1 November 2015*

[132] *Focus group discussion, boys, Batticaloa, Sri Lanka, 5 November 2015*

[133] *Focus group discussion, young men, Batticaloa, Sri Lanka, 5 November 2015*

[134] *Individual interview, nurse, Colombo, Sri Lanka, 3 November 2015*

[135] *The Women's Support Group, Sri Lanka, The Status of Lesbians, Bisexual Women and Transgendered Persons in Sri Lanka NGO Shadow Report to the Committee on the Elimination of All Forms of Discrimination Against Women, January 2011, p. 3, accessed 14th October 2015 http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/WSG_SriLanka48.pdf*

14.4 Impacts of criminalisation: protection from violence

The research also revealed evidence that LGBT groups face limited legal protection from violence, extortion and other types of discrimination, both by state and non-state actors. A group of MSM in a FGD in Colombo spoke of how they are subject to harassment and attacked by people on the streets: "when I walk along the road, people call me names and make me feel ashamed. People steal my things. They sometimes take me by force and rape me".[136]

The Sri Lankan constitution does not explicitly guarantee protection on the grounds of sexual orientation, gender identity and/or gender expression. The Constitution does not indicate that the term "sex" includes a wider interpretation than the binary, biological classification between male and female. This puts persons identifying as LGBTI at specific disadvantage in accessing rights and legal protections.

In its response to the Human Rights Committee in 2014, the Sri Lankan Government stated that Article 12 of the Constitution which recognizes non-discrimination based on the grounds of race, religion, language, caste, sex, political opinion, place of birth or any one of such grounds as a fundamental right also protects persons from stigmatization and discrimination on the basis of sexual orientation and gender identities and that that under Article 12.2 "laws discriminating on the grounds of sexual orientation and gender identity are unconstitutional". Although this is a welcome step, no action has been taken to make this explicit in the law.[137] There is also an absence of anti-discrimination laws that protect LGBTI persons, resulting in a failure to protect against widespread discrimination in a range of areas such as employment, housing and health care.[138]

14.5 Lack of legal recognition in relation to transgender

No official policy exists to provide for the change of gender on legal identity documents, such as birth certificates or ID cards, nor for individuals to be able to identify as anything but male or female on such documents.[139] There is also a lack of an adequate legal framework in relation to sex reassignment surgery.[140] In practice, a person appears to need to change their gender on official documents first, for which no process exists, before they can undergo sex reassignment surgery. A medical practitioner performing the surgery would also risks losing their license if they performed surgery on someone who had not altered their gender on official documents.[141] This makes it effectively impossible for transgendered or intersex individuals to be legally recognised according to their gender identity and also limits their ability to access sex reassignment surgery. A transwoman interviewed in the qualitative research explained the impact that this has on her: *"although I understand that I am a woman, according to the law I am not completely woman. I face many challenges. I need a specialist doctor, but they aren't that many in Sri Lanka."*

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[136] *Focus group discussion, MSM and TG community, Colombo, Sri Lanka, 1 November 2015*

[137] *Outright Action International "Sri Lankan Government says LGBT rights are constitutionally protected", accessed 19th October 2015 https://www.outrightinternational.org/content/sri-lanka-government-says-lgbt-rights-are-constitutionally-protected.*

[138] *Kaleidoscope, Shadow Report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), September 2014, p. 5, accessed 20th October 2015. http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/09/Sri-Lanka-Report-Final.pdf.*

[139] *Kaleidoscope, Shadow Report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), September 2014, p. 5, accessed 20th October 2015. http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/09/Sri-Lanka-Report-Final.pdf*

[140] *Kaleidoscope, Shadow Report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), September 2014, p. 5, accessed 20th October 2015. http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/09/Sri-Lanka-Report-Final.pdf*

[141] *Kaleidoscope, Shadow Report to the UN Human Rights Committee regarding Sri Lanka's protection of the Rights of LGBTI Persons (Response to List of Issues), September 2014, p. 5, accessed 20th October 2015. http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/09/Sri-Lanka-Report-Final.pdf*

Law and Sex Work

Another group of individuals who experience significant barriers to access to SRH services, including legal protection from violence and abuse, due to the law and legal barriers are individuals who engage in sex work or the selling of sex.

Sex work in Sri Lanka is not illegal per se, however, the Penal Code provides that a woman who engages in street sex work may be subject to arrest, detention and conviction under the colonial Vagrants Ordinance 1842, section 7 which criminalises soliciting in a public place *"for the purpose of the commission of any act of illicit sexual intercourse or indecency"*. The fact that there is no clear definition of soliciting in the legislation is troubling and has led to inconsistent interpretation, implementation and misuse of the law. Previous research has revealed that woman have been arrested simply for having condoms in their handbags as well as faced other types of harassment from authorities.[142]

Legal criminalisation of sex work reinforces the deep shame and stigma associated with being a sex worker and the selling of sex, which places women who sell sex at risk of harassment and violence: from their clients, their families and society, as well as law enforcement authorities. Respondents in the research relayed numerous disturbing accounts of the abuse that they are subject to from others, including by police, and explained that they have no recourse to justice or support because of the illegal status of their activities: *"the police beat us, pull our hair and put us in a van. They will keep us all night and sometimes the police will have sex with us by force. They will keep us in prison for two weeks and do medical examinations… They don't care about our consent."*[143]

Feelings of shame and disempowerment from this treatment reduce women's likelihood of seeking access to SRH services from other sources, especially in the case that they have been victims of sexual violence and abuse: *"in our life we would never go to the clinic so it is better to [let them] force us."*[144] Individuals who sell sex accessed for the study were accessed through a support organisation that works in particular with sex workers, and provides them with basic SRH services; thus they were able to access services such as contraception and STI testing in practice. However their responses suggest that they would be unlikely to seek other services elsewhere. Furthermore, it suggests that sex workers and individuals who sell sex who are not accessing a specialised centre are likely to face significant barriers to accessing services.

Women who sell sex may feel that because they are selling sex they do not deserve assistance or support in the first instance, and this perception is reinforced by the criminal status of the work under the law, which functions as a barrier to women seeking access to justice when they are subject to abuse. As a group of women who sell sex interviewed for the study in Colombo explained:

> *"Sometimes clients get our services and then they beat us and take our money. We can't go to the police station. Since what we are doing is illegal how will we go to the police? If we go to the police station and complain they will arrest us! Sometimes they take all our clothes and all our money that we have made for the day."*[145]

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[142] *Women and Media Collective, List of Issues and Questions raised by the CEDAW Committee with the state party on the combined fifth, sixth and seventh periodic report of Sri Lanka, January 2010, p. 5, accessed 16th October 2015. http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT_CEDAW_NGO_LKA_48_9523_E.pdf*

[143] *Focus group discussion, women who sell sex, Colombo, Sri Lanka, 6 November 2015*

[144] *Focus group discussion, women who sell sex, Colombo, Sri Lanka, 6 November 2015*

[145] *Focus group discussion, women who sell sex, Colombo, Sri Lanka, 6 November 2015*

Importantly, the women who were selling sex included in the qualitative research had very limited understanding of the specific legal provisions that apply to sex work, appearing to believe that sex work is entirely illegal, and that only the selling of sex (as opposed to the purchase of sex) is criminalised:

> *Are there any circumstances or places where sex work is legal?*
> *It is always illegal.*
>
> *Who gets into trouble – the sex worker or the client?*
> *Only the sex worker…*[146]

This perception, which may reflect social stigma surrounding the selling of sex, is likely to serve to reinforce barriers to accessing basic rights and services.

Conclusions and Implications

This research was designed to investigate the influence of law and legal norms on young people's sexual and reproductive rights, and, in particular, young people's ability to seek and be provided with sexual and reproductive health services in Sri Lanka. The study explored a range of legal provisions relevant to young people's access, including laws that impact on access to services directly, through explicitly restricting the delivery of and/or access to specific services for certain groups of young people in certain circumstances; laws that impact on access to services indirectly, through functioning to limit young people's access in practice; and laws that facilitate young people's access through explicitly providing young people with legal rights and protections.

The Sri Lankan government has taken positive steps recently, which reinforce and strengthen young people's access to their sexual and reproductive rights. The recent government circular 01-25/2015 issued to service providers in 2010, which removes penalties for failing to report a child protection concern, and clarifies that young people should be provided with SRH services when this is in their best interest, appears to have improved access to services, particularly through encouraging the provision of services by health care providers. Despite this progress, however, there appears to be a need for strong facilitative provisions, which clearly protect young people's right to access services independently and confidentially, and guarantee them access to general services, such as sexual and reproductive health education.

Indeed, research findings suggest that significant barriers prevent young people from seeking and accessing SRH services in Sri Lanka, some of which relate to the law. For instance, legal restrictions on young people's access to abortion, both create barriers to access to abortion services and serve to increase levels of stigma around accessing other SRH services. Additionally, findings suggest that in the context of extremely restrictive socio-cultural norms regarding extramarital sexual activity, legal provisions which establish the age of sexual consent and legal minimum age of marriage, as well as definitions of sexual violence that fail to criminalise rape within marriage, may create barriers to young people's seeking of services by shaping young people's (and to a lesser extent service providers') understandings and expectations about when they can legally access services.

Analysis of the interactions between law and socio-cultural barriers suggest that social norms often drive the application and interpretation of law: for instance the operation of legal barriers such as the legal minimum age of marriage were often found to be a reflection or symptom of underlying restrictive norms, rather than the driving force behind them.

[146] *Focus group discussion, women who sell sex, Colombo, Sri Lanka, 6 November 2015*

In this context, addressing barriers to access is not simply a question of removing specific restrictive legal provisions, but addressing underlying norms themselves. At the same time facilitative legal provisions that explicitly promote and protect young people's rights and access may be particularly important. Indeed, findings from the study suggest that in light of restrictive social norms relating to young people's sexuality and sexual activity, silence and ambiguity in the law may result in the assumption by both service providers and young people themselves that access to services should be / will be restricted. For instance, in Sri Lanka, where law and policy do not explicitly state that young people have the right to access a service confidentially, the study suggests they are likely to assume that they do not and refrain from accessing services at all.

Finally, findings suggest that in a restrictive context it is essential for young people to receive education about sexual and reproductive health, their rights, and the services that are available to them. Education is particularly important as confusion and contradictions surrounding law and policy can serve to restrict young people's access; where young people experience doubt about their right to confidential advice and services they are likely to be discouraged from attempting to access services in practice.

16. Recommendations for legal reform

The research findings do suggest that a number of legal reforms have the potential to improve young people's access to SRH services in Sri Lanka:

16.1 Age of sexual consent

- The research reveals that age of consent laws, which establish the minimum age of sexual consent at 16 for both boys and girls, may create indirect barriers to young people's access to SRH services. Accordingly, the law on the age of sexual consent should make a distinction between (1) factually consensual sexual activity taking place in the context of a child's sexual development, and (2) sexual activity that by its very nature is exploitative. **Consensual sexual activity between adolescents who are close in age should not be criminalised,** in recognition of the fact that many young people commence sexual activity during early adolescence.
- **We recommend a 'close-in-age' approach to sexual consent, which considers the age difference between parties, rather than criminalising all sexual activity below a specific age.** The law should also consider whether one of the parties to the relationship is in a position of power, trust, authority, or dependency in relation to the other (e.g. the relationship between a teacher and student; a doctor and patient etc.). In such cases the age of sexual consent should be higher than in cases where there is not a power dynamic at play. It is important to provide health professionals with a certain amount of discretionary power to distinguish between cases of consensual sexual activity and cases that raise child protection concerns.
- Finally, young people and service providers should be made aware that the age of sexual consent does not mean the age of consent to medical treatment and does not imply restrictions on young people's access to services.

16.2 Consent to medical treatment, including SRH services

- **We recommend the adoption of a positive provision in primary legislation, which clearly establishes young people's right to access SRH services, and recognises their capacity / competency to do so independent of parental or other consent.** Such a provision is important in order to avoid ambiguity and the risk that informal restrictions will be applied at the discretion of service providers.

- While the previously mentioned government circular is a positive step in this regard, it still leaves service provision to the discretion of the service provider and encourages the provider to obtain parental consent before providing a service.

16.3 Confidential access to services

- We recommend the development of legislation or legislative guidance that explicitly protects young people's right to access SRH services (including consultations, contraceptives and testing) confidentially to ensure that this right is respected and taken seriously by service providers in all cases, including within schools. Young people should also be informed of their right to access services confidentially, including through comprehensive sexuality education (recommendation 16.4).
- Where a child reveals abuse and provides consent, a service provider may share information as far as it is necessary in order to facilitate a formal child protection response. Young people should always be informed of what information will be shared, who will receive it and for what purpose. Additional measures should be put in place to protect children from further harm during that process
- It may be necessary to develop industry specific guidelines that inform service providers and practitioners about how to implement young people's confidentiality rights. It may also be helpful to deliver capacity building to service providers on the implications of legislation for their work.

16.4 Access to comprehensive sexuality education

- There is currently no national legislation mandating universal comprehensive sexuality education in Sri Lankan schools. **Comprehensive sexuality education should be a mandatory part of school curricula according to law or legislative guidance, and should be introduced before the age of puberty.**
- In all cases, sexuality education should avoid propagating dominant stereotypes about sex and gender, and should seek to present information as objectively and accurately as possible. This curriculum should include information on diverse gender and sexual identities. It should also clearly explain the SRH services that are available for young people, as well as their rights to access these services, and the content and implications of relevant provisions in law.
- Sexuality education should not focus on promoting abstinence, as this is likely to contribute to stigma and other social barriers to young people accessing SRE. It should go beyond a narrow focus on biological and reproductive aspects of sexual health, and empower young people with skills in decision making and communication.

16.5 Access to abortion

- Abortion in Sri Lanka is currently prohibited except in cases where it is carried out in order to save the life of the mother. The criminalisation of abortion creates direct legal barriers to access to sexual and reproductive health services; **provisions criminalising abortion in the Penal Code should be removed.**
- **Abortion services should be made free, safe, accessible and confidential for all women and girls.** The law should not contain any restrictions relating to the circumstances which led to the pregnancy, or the age or marital status of the woman or girl. A woman or girl should never be criminalised for accessing an abortion.
- Given the deep stigma surrounding unmarried/adolescent pregnancy in Sri Lanka, **we also recommend the development of legal provisions to protect pregnant women and girls from discrimination, including in school, in the workplace and in accessing services.** All policy interventions aimed at

reducing rates of teenage pregnancy must be framed with respect for a young women's choice and autonomy (including her choice to become pregnant), need for services, and absolute right to live in freedom from discrimination. This is essential to avoid reinforcing harmful cultural narratives that expose young pregnant girls to stigmatization and discrimination, in ways that have a significant impact on SRH and access to services.

16.6 Heteronormativity

- All criminal provisions prohibiting same-sex sexual activity should be removed from law, including Section 365(a) of the Criminal Code.
- Strong legal provisions protecting LGBTI identified persons from discrimination should be developed, and equality laws should be extended to apply specifically to LGBTI people.
- Specialized services such as gender reassignment surgery and hormone supplements should be made available and accessible.

16.7 Sexual and gender-based violence

- The failure to recognize, in law, all forms of gender-based and sexual violence (GBV), particularly marital rape, as well as the failure to implement laws, can have a serious impact of SRH and access to services.
- The law should be amended to recognise all forms of GBV regardless of the context (e.g. in the home, school community or within other institutions) or relationship (e.g. whether married or not) within which it occurs. **In particular, Section 363(a) of the Sri Lankan Penal Code should be amended to explicitly criminalise marital rape.**
- Sexual abuse should be defined in terms of absence of consent, rather in terms of 'force' or violence.
- **All acts of sexual violence, including both physical and non-physical acts of violence, should be criminalized within law.**

ANNEX A: Data Collection Tools

Survey Young People

Location of survey (where respondent was accessed):

(*IPPF MA to fill out*): _____

Please number the survey and fill in your initials here:_____

Instructions: Our organisation [fill in name of MA] is conducting some research about children and young people's access to sexual and reproductive health services, and we're interested to hear about your ideas and experiences.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: there are not right or wrong answers to most of the questions and we want to learn from you! We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

The purpose of the research is to identify any barriers, which make it difficult for young people to access sexual and reproductive health services, such as contraceptives or other health services they need. Based on what we learn through the survey, we will make recommendations on how service providers can improve young people's access.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. We don't mind if you prefer not to take the survey, and it won't affect your interactions with [fill in name of MA] in the future. Would you like to take the survey?

Yes ☐ No ☐

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ☐ No ☐

PART 1: Basic personal and household information		
1.1	Gender (circle one)	Female / Male / Other _____
1.2	Age (fill in):	_____ (number)
1.3	**Where do you live?** (fill in)	_____ (village)/ _____ (district)
1.4	How would you describe the area where you live? (circle the best response)	1. Rural area 2. Town (semi-urban) 3. Urban neighbourhood 4. Urban slum 5. Suburban area 6. Refugee camp
1.5	Total size of household (fill in):	_____ (# females)/ _____ (# males)
1.6	Who do you live with / who looks after you? (circle the best answer)	1. I live with both my parents 2. I live with a single parent 3. I live with relatives (not a parent) 4. I live with other adults (not relations) 5. I live with my partner

1.5	Total size of household (fill in):	_____ (# females)/ _____ (# males)
1.6	Who do you live with / who looks after you? (circle the best answer)	1. I live with both my parents 2. I live with a single parent 3. I live with relatives (not a parent) 4. I live with other adults (not relations) 5. I live with my partner
1.7	**How many siblings do you have in total? How many of these siblings are older than you?** (fill in)	Number of siblings_____ (number) Number of older siblings_____ (number)
1.8	Level of education (select the best answer):	1. No formal education 4. Secondary 2. Elementary 5. College / university 3. Primary 6. Other
1.9	**Do you do any work for a wage?** (circle the best answer)	1. Yes, full time 2. Yes, part time 3. No
1.10	**Religion** (select the best answer):	1. Hindu 4. Sikh 2. Muslim 5. Christian 3. Buddhist 6. Other
1.11	**Do you identify as an individual belonging to a social/racial/ ethnic minority group?** (circle the best answer)	Yes / No
1.12	**Do you believe that you have any form of partial or permanent disability?** (circle the best answer)	Yes / No
1.13	**Which of the following is present in your household?** (circle all that apply)	1. A refrigerator 6. Piped water 2. A mattress 7. A flush toilet 3. A television 8. A gas cooker 4. A computer 9. A car 5. A mobile telephone 10. Internet
1.14	**What is the occupation of the head of your household?**	1. Farmer 2. Casual labourer 3. Government employee 4. Factory worker 5 . Shopkeeper 6. Employee of private company 7. NGO 8. Hospitality 9. Household help 10. The head of my household does not engage in any income earning activities 11. Other
1.15	**Marital status (select the best answer):**	1. Never married 4. widowed 2. Married now (living together) 3. Separated/divorced 5. other

PART 2: Knowledge and perceptions of norms and law		
2.1	**In your view, at what age is it appropriate for young people to become sexually active?** (select the best answer)	1. At the age of : _____ (fill in age) 2. When he or she is married 3. It depends (no particular age)
2.2	In your view, at what age is it appropriate to get married? (select the best answer)	1. At the age of : _____ (fill in age) 2. It depends (no particular age)
2.3	**Does the law say that it is illegal to have sex if you are below a certain age?** (select your best guess)	Yes / No
2.4	**If so, what is the age ?** (fill in with your best guess or circle 'no age')	_____(for boys) _____ (for girls)/ No age
2.5	**Does the law say that it is illegal to have sex with someone else who is below a certain age?** (circle your best guess)	Yes / No
2.6	**If so, what is the age ?** (fill in with your best guess or circle 'no age')	_____(for boys) _____ (for girls)/ No age
2.7	**In your view, at what age should a young girl be able to access contraceptives?** (circle the best answer)	1. At the age of: _____ 2. When she is married (regardless of whether or not she has already had a child) 3. Once she is married (but only after she has already had her first child) 4. At any age
2.8	**Does the law set an age at which young people are able to access any forms of contraceptives / birth control?** (circle the best answer)	1. Yes 2. No 3. No age, but legal access is at the discretion of the service provider
2.9	**If yes, what is that age?** (fill in with your best guess)	_____
2.10	**According to the law, can the doctor tell your parents without your permission if you go to access contraceptives?** (circle the best answer)	1. Yes; the law requires her to tell my parents when I access a service 2. Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3. Only if there is a risk to my health 4. Never under any circumstances
2.11	**According to the law, can the doctor tell your parents without your permission if you go to access STI testing?** (circle the best answer)	1. Yes; the law requires her to tell my parents when I access a service 2. Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3. Only if there is a risk to my health 4. Never under any circumstances

2.12	**According to the law, can a 17 year old girl access an abortion?** (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1. Yes, always 2. Only with her parent's permission 3. Only if she was raped 4. Only if her life is in danger 5. Never under any circumstances
2.13	**According to the law, can a 14 year old girl access an abortion?** (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1. Yes, always 2. Only with her parent's permission 3. Only if she was raped 4. Only if her life is in danger 5. Never under any circumstances
PART 3: Experiences accessing services		
3.1	**At what age did you first have sex?** (fill in your age OR circle 55 OR 99)	Age____ 99 Never had sex 55 I don't want to answer
3.2	**If you ask a doctor or midwife for advice about contraception or STI testing, do you feel confident that they will they keep this information confidential? (circle the best answer)**	Yes / No / Maybe
3.3	**Have you ever tried to access any of the following services?** (circle all that apply)	1. Condom 2. Oral contraceptive pill services 3. Injections 4. Implant/IUD 5. STI testing (non HIV) 6. HIV testing 7. Abortion 8. Emergency contraception 9. Sterilisation 10. Ante natal 11. Post natal services 12. SGBV related services
3.4	**Where have you tried to access the services you just mentioned?** (circle all that apply)	1. Public clinic 2. Private (fee-paying) clinic 3. School health centre 4. Clinic specialising in SRH 5. Pharmacy 6. Community member 7. Other (please specify)

3.5	**Have you ever been denied access to any of the following services?** (circle all that apply)	1. Condom 2. Birth control pill 3. Injections 4. Implant/IUD 5. STI testing (non HIV) 6. HIV testing 7. Abortion 8. Emergency contraception 9. Sterilisation 10. Ante natal services 11. Post natal services 12. SGBV related services
3.6	**Have you been denied access to a service because of your age?** (circle all that apply)	1. Condom 2. Oral contraceptive pill 3. Injections 4. Implant / IUD 5. STI testing (non HIV) 6. HIV testing 7. Abortion 8. Emergency contraception 9. Sterilisation 10. Ante natal services 11. Post natal services 12. SGBV related services
3.7	**If you have ever been denied access to a service because of your age, please specify the age at which this occurred** (fill in, or circle 99)	Age ____ 99 I have never been denied access because of my age
3.8	**Have you been unable to access an SRH service because of your sexual/gender identity?** (circle the best answer)	Yes / No
3.9	**Has anyone ever had sex with you or committed sexual acts with you through force or against your will? For example through pressure, coercion, physical force, or because you were unable to say no?** (circle the best answer)	Yes / No / I prefer not to say
3.10	**Have you received any education about sexual and reproductive health services?** (circle all that apply)	1. Yes, at school 2. Yes, from a religious/community leader 3. Yes, from an NGO 4. No, never

Survey Service Providers

Location of survey (where respondent was accessed):

(*IPPF MA to fill out*): _____

Please number the survey and fill in your initials here:_____

Instructions: Our organisation [fill in name of MA] is conducting some research about children and young people's access to sexual and reproductive health services, and the way that access is regulated by law.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: we want to learn from your knowledge and experiences. We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. Would you like to take the survey?

Yes ☐ No ☐

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ☐ No ☐

PART 1: Basic personal and household information		
1.1	**Gender** (circle one)	Female / Male / Other _____
1.2	**Age** (fill in):	_____ (number)
1.3	**Which of the following best describes your place of work? (circle one)**	1. Public clinic 2. Private (fee-paying) clinic 3. School health centre 4. Clinic specialising in SRH 5. Pharmacy 6. Hospital
1.4	**Where is your place of work located?**	_____(village)/_____(district)
1.5	**How would you describe this area?** (circle the best answer)	1. Rural area 2. Town (semi-urban) 3. Urban neighbourhood 4. Urban slum 5. Suburban area 6. Refugee camp

1.6	**Which of the following services do you provide?** (circle all that apply)	1. Condom 2. Oral contraceptive pill 3. Injections 4. Implant / IUD 5. STI testing (non HIV) 6 .HIV testing	7. Abortion 8. Sterilisation 9. Ante natal services 10. Post natal services 11. SGBV related services 12. Gender reassignment treatment
PART 2: Laws regulating sexual activity			
2.1	**Does the law say that it is illegal to have sex if you are below a certain age?** (select your best guess)	Yes / No	
2.2	**If so, what is the age ?** (fill in or circle 'no age')	___ (for boys) ___ (for girls)/ No age	
2.3	**Is it legal to provide contraceptives to young people under this age?**	Yes / No / It depends	
2.4	**Does the law say that it is illegal to have sex with someone else who is below a certain age? (circle your best guess)**	Yes / No	
2.5	**If so, what is the age?** (fill in or circle 'no age')	___ (for boys) ___ (for girls)/ No age	
2.6	**Is it legal to provide contraceptives to young people under this age?**	Yes / No / It depends	

PART 3: Laws regulating provision of services to young people

This section lists a number of sexual and reproductive health services (in the columns) and possible ways in which young people's access to the services is regulated by the law (in the rows). Circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether or not the statement about the law is true in relation to that particular service.

	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
It is only legal to provide this service to young people 18 years and above	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to young people 15 years and above	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to a minor with their parent's consent	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I may only provide this service to a minor based on my assessment of their competence	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

According to the law, I may only provide this service to a minor if he or she is married	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
There are no legal restrictions on the provision of this service	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 4: Laws regarding confidentiality of young people's access to services

This section is about the confidentiality and reporting requirements that apply to the provision of services to young people. Again, circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether the statement about the law applies to that service.

	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
According to the law, if a minor (under the age of 18) accesses this service I am required to inform his or her parents (even if he or she does not consent to my doing so):	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, if a minor accesses this service I am not required to inform her parents, but I may do so at my discretion:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am only permitted to inform a minor's parents (without her consent) if there is a risk to her health:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am required to protect a minor's confidential access under all circumstances	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 5: Service provision in practice (circle the best answer to each question in relation to each service listed below)								
	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV Testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
Have you ever denied someone access to the following services because of their age?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you ever denied someone access to the following services because of their gender/sexuality?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
In your capacity as a service provider, have you ever reported a case to the police/child protection services because you learned a minor was sexually active under the age of 18?				Yes / No				
What happens if you fail to do so?				1. I risk going to jail 2. I risk losing my job 3. Nothing at all				
Is it ever your responsibility to encourage someone to be sterilised? (circle all that apply)				1. Yes, if they have a severe disability 2. Yes, if they already have too many children 3. Yes, if they have (or are planning to) change their gender ever under any circumstances 4. In none of these circumstances				

Questionnaire Schedule (service providers)

Interview details

Interviewer's name:

Date:

Location (please give details):

Information about interviewee

Position in the organisation:

Number of years in position:

Previous work?

Have you received any training or education which helps you in your work?

Any other information:

Information about the service

Name of the service:

Introductory questions

1. Could you tell me a little about your organisation? What is your role at the organisation? What SRH services do you provide (contraception, sexual testing, abortion, etc.), and to whom?

2. Do you provide services to young people? Do many young people access your services? Is it easy or difficult for young people to access your services? Why? Are there any difference in services you provide to young people and those you provide to adults? Do you do outreach services? What kinds/ where (i.e. in schools?)

SRE

3. In your experience, how well informed are young people about SRH? Where do they learn about these issues?
4. Are there any laws/ policies that regulate SRE for young people? Are they implemented in practice? What do you think of these?

Law and Consent

5. Are there any legal restrictions on access to your services based on age? (probe on access to particular types of services, e.g. contraception, STI testing etc.)
6. Do you require consent from parents/ legal guardians for young people/ children to access your services below a certain age?
7. What is the age of sexual consent in India? What is the legal age of marriage? Does this have any impact on accessing services? How/ why?
8. If a child comes to you under the legal age of sexual consent, and reveals they are sexually active – how would you manage this? Would you take any action/ what? What does the law say about this? Are there any obligations on you as a service provider to take any action under the law? Do you agree with this? Why/ why not?

Law and confidentiality

9. If a young person comes to access your service is it ever appropriate to tell anyone about this? When and who? What, if anything, does the law have to say about this? Is confidentiality important for young people's access to services? Why/why not?

Law and abortion

10. Do you provide any abortion services? Who is legally able to access abortion services and under what conditions? What are the legal restrictions on access to abortion? Do you think this creates any barriers to access to services? For whom? What are the reasons that the law is this way? What are your views on this?
11. At what age can you have a legal abortion? Are there any age restrictions? If a young girl needs to access an abortion, does she require consent from anyone? Who? Does a married woman need the consent of her husband? What are the reasons that the law is this way? What are your views on this?
12. Can you tell me a little about the Preconception and Prenatal Diagnostic Techniques Act (law prohibiting sex-determination/ selective abortion). What are the reasons for this law? What are your views on this? Does this impact (and if so how) on women's ability to access particular tests and scans? Does this law have an impact on women's access to abortion more broadly? How?
13. In your experience, is there social stigma about getting an abortion? Who/where does this come from? Do you think this currently affects how girls use SRH services?

Law and sterilisation

14. Do you provide sterilisation services? Are these services common? Who are these services generally provided to?
15. Are there any government policies (or laws) that provide for/ regulate/ restrict sterilisation services? Can you tell me about these? What do they say? What do you think of these? (If they don't bring up the 2-child policy probe).
16. What are your views on sterilisation? Would you ever recommend/ encourage someone to get sterilised? Who? Why/ why not?
17. Are there any age restrictions on access to sterilisation? Whose consent is required for sterilisation? (e.g. person being sterilised/ parent/ guardian/ partner etc.)
18. Would you ever consider providing sterilisation services to someone without their consent? Who? (probe: e.g. people with disabilities, mental health problems etc.)

Law, gender and sexuality

19. Do you provide any services for trans-gender/ third sex individuals? Do you provide any sex reassignment services? If not, why not? Where would a person go to access these services?
20. Do you know about any laws or policies that regulate these services/ access to services for these groups? What are they? What do you think of them?
21. Are there any additional hurdles/ challenges, do you think, for third sex/ trans people to access mainstream SRH services (e.g. family planning services, STI testing/ treatment, general health care services etc.)
22. Does the law say anything about same-sex relationships/ sexual activity? What? Is this law implemented? What is the impact of this law in practice?
23. Does this create any barriers to access to services for homosexual people? Why/ why not?
24. Is there any obligation on you as a service provider to report children engaged in homosexual relationships/ sex?

Law and sexual violence

25. Do you ever find that your patients / people accessing your services have been victims of sexual violence
26. Do you provide any services for victims of sexual violence? What are these?
27. What are the main forms of violence related to sex and gender that predominantly affect young people in your experience?
28. Do you think the law effectively protects young people against violence? In your experience are young people reporting incidents of violence believed?
29. Do you think laws in relation to sexual violence have any impact on access to SRH services, especially for young people? If so, how/ why?

Conclusion

30. Do you think that young people in this have access to the SRH services they want and need?
31. What do you think are the biggest challenges in ensuring comprehensive and equitable access to SRH services for young people?
32. Are there any problems specifically with the law? Is there anything that should be different?
33. What are your recommendations for improving young people's access to SRH?

Focus Group Discussion Guide

Interview details

Interviewer's name:

Date:

Location (please give details):

Introduction

Briefly explain research/confirm consent.

Introduce researcher: name, age, where from, religion, gender/sexual identity.

Ask the participants if they would like to introduce themselves. Say they can give as little or as much information about themselves as they like, depending on what they think is most relevant.

General Questions

At what age do young people in your community get married?

Is there a law about this? What does it say?

At what age do young people in your community start having sex?

Is there a law about this? What does it say?

Where do you learn about SRH? Who do you speak with about it?

Scenarios

Your friend/sister is 15 years old. She has a boyfriend. He keeps asking her to have sex with him.

- What do you think she should do? What advice would you give her?
- Would your feelings/advice be different if your friend was a boy/your brother?

What if she says no, but he won't stop pressuring her and eventually she gives in:

- Does this happen in your community?
- How do you feel about this situation? What advice would you give your friend/sister?

See if they bring up contraception. If not, prompt them.

- Do you think they would use contraception? What kind/type?
- Where would they get contraception from? (If respondents bring up more than one type of contraception, probe to get details about each type).
- Would it be difficult for them to get contraception? Yes, No, Why?
- Does it matter how old they are?
- How much would it cost?
- Would they need anyone's permission (e.g. parents)?
- Who would be more likely to seek contraception? The boy or the girl? Why?
- Is there a law about this? What does it say?

A couple of months later your friend/sister comes to you and tells you she is pregnant...

- What advice would you give to her?
- Would she tell her family or anyone else? Who would she tell? Why?
- What would her options be? Can she have an abortion? What factors would influence her choice?
- Would there any costs?
- Does her age matter?
- Does it matter if she's married?
- Is there a law about this? What does it say?

Now imagine your friend/ sister has the baby...

- Is she likely to seek any other medical services? What type?
- If she's in school, how might her school react? Would she be able to continue studying?
- Is there a law about this? What does it say?

Another good friend of yours has just gotten married. She confides in you that she is not ready to have a baby (even though her husband wants one) just yet because she is still young...

- How do you feel about this situation?
- What advice would you give her?
- Could she access contraception if she wanted to?
- Would she need her husband's permission? Why/ why not?
- Is there a law about this? What does it say?

Your friend decides that the best thing to do to avoid pregnancy is to abstain from sex during certain times of the month. On one of these days that she refuses, her husband forces her to have sex with him anyway...

- How do you feel about this situation?
- What advice would you give your friend?
- Your friend says she was raped by her husband and she wants to seek medical advice/go to the police. Is this an option?

- Does it matter whether her husband was physically violent?
- If your friend did seek help, how do you think she would be treated by health workers/ police?
- Is there a law about this? What does it say?

(Boys) your friend comes to saying that he is having some problems with his penis and sex.. (Girls) your husband is having some problems having sex..

- What advice would you give him?
- Do you think he would seek advice? Where from?
- Would help/services cost money?
- Is there a law about this? What does it say?
- What are the main sexual health problems that men/boys in your community face? Why? What do you think causes these problems?

Now imagine the person experiencing health issue is a women/girl...

- What are the main sexual health problems that women/girls in your community face? What do you think causes these problems?
- Do women/girls seek help/service for sexual health problems? From who?
- Do these services cost money?
- Is it difficult for young women to access these services? Why/why not? Do they need anyone's permission? E.g. parents/ husbands.
- Is there a law about this? What does it say?

If they don't bring up HIV prompt them...

- Have you heard about FGM? What do you think about this practice? What does the law say about FGM?
- What about HIV and AIDS – is this a problem in your community? Do young people worry about HIV? What do they do to protect themselves? Is there a law about HIV?

Questions about gender and identity

I now have a few strange questions. They are not "trick questions". Just say what you think...

Have you ever heard of being homosexual? Do you have these groups in India/Sri Lanka? Have you ever heard of being transgendered? Do you have these groups in India/Sri Lanka? What problems (if any) do these groups of people face? Are there any laws related to these things? What does the law say? Is it legal to be homosexual in India / Sri Lanka? Is it legal to change your sex?

Is there such a thing as "good" and "bad" behaviour when having sex? Where do these ideas come from? Do you agree? How do you think these ideas effect young people when they try to access sexual and reproductive health services?

Final Questions

Do you think that young people in India / Sri Lanka have access to the SRH services they want and need?

What do you think are the biggest problems (if any) that young people face with SRH?

Are the any problems specifically with the law?

Is there anything that should be different?

ANNEX B: Ethical Protocol

Coram Children's Legal Centre

Ethical Guidelines for Field Research with Children

Each research project carried out by Coram Children's Legal Centre should be ethically reviewed and Guidelines should be developed that are tailored and relevant to each piece of research. The reason for this is that different types of research will raise unique, context-specific ethical issues and it will be necessary to identify and address these issues on a project-specific basis. However, these Guidelines should be applied when carrying out all project-specific ethical reviews.

1. Application of Ethical Guidelines

The Ethical Guidelines will apply to all field research carried out by Coram Children's Legal Centre and organisations and individuals carrying out research on behalf of Coram Children's Legal Centre. The Guidelines will not apply to the consideration and selection of research projects. They will apply to: methodology selection and design; the design of data collection tools; the collection, storage, collation and analysis of data; and the publication of research.

2. Ethics review

All research project methodologies and data collection, collation and analysis tools must be approved by the Director, International and Research or the Legal Research and Policy Manager, before they are deployed. The Professional Director or Legal Research and Policy Manager will review the methodologies and tools in light of these Guidelines and best practice, and make revisions accordingly, which will then be incorporated into revised methodologies and tools.

3. Selecting researchers

Coram Children's Legal Centre will ensure that all external researchers have the necessary experience to carry out the research required. Where necessary, training will be provided to external researchers by Coram Children's Legal Centre staff on these guidelines and best practice issues for carrying out the relevant research.

4. Guiding principles

All research projects will be subject to the following ethical principles.

4.1 Do no harm and best interests of the child

It is of paramount importance that Researchers protect the physical, social and psychological wellbeing, and the rights, interests and privacy of research participants. The welfare and best interests of the participants will be the primary consideration in methodology design and data collection. All research will be guided by the UN Convention on the Rights of the Child, in particular Article 3.1 which states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts or legislative bodies, the best interests of the child shall be a primary consideration."

It is the obligation of the Researcher to identify and avoid harmful effects. If Researchers identify that they are causing harm to a participant/s, the research must be stopped.

Particular care will be taken to ensure that questions are asked sensitively and in a child-friendly, manner that is appropriate to the age, gender, ethnicity and social background of the participants. Clear language will be used which avoids victimisation, blame and judgement. Where it is clear that the interview is having a negative effect on a participant, the interview will be stopped. Any child protection concerns will be identified and dealt with appropriately (see 4.8, below).

Children will be provided with the opportunity to participate in data collection with a trusted adult or friend if this would make them feel more at ease. Researchers should identify staff at institutions (e.g. schools, community groups, detention centre staff) that are available to accompany participants, if requested.

Interviews may cover particularly sensitive or traumatic material, and it is important to ensure that participants feel empowered and not solely like victims. Interviews should finish on a 'positive or empowering note' (e.g. through asking questions about what would improve the situation of children in the relevant study sample). This will help to ensure that children do not leave the interview focusing on past experiences of abuse. Where children reveal past experiences of violence or abuse, researchers will convey empathy, but will not show shock or anger, as this can be harmful to children who have experienced violence.

4.2 Data collection must be necessary

It is important to ensure that unnecessary intrusion into the lives of participants is avoided. Researchers must ensure that the data being collected is necessary to address the research questions specific to each project. Data collection for extraneous purposes must be avoided.

Where possible and appropriate, participants may be provided with material incentives to compensate them for time spent contributing to the research.

4.3 Researchers must not raise participants' expectations

Researchers must carefully explain the nature and purpose of the study to participants, and the role that the data will play in the research project. Participants should also be informed that the purpose of the Researcher's visit is not to offer any direct assistance. This is necessary to avoid raising expectations of participants that the Researcher will be unable to meet.

4.4 Ensuring cultural appropriateness

Researchers must ensure that data collection methods and tools are culturally appropriate to the particular country, ethnic, gender and religious context in which they are used. Researchers should ensure, where possible, that data collection tools are reviewed by a researcher living in the country context in which research is taking place. Where possible, data collection tools should be piloted on a small sample of participants to identify content that lacks cultural appropriateness and adjustments should be made accordingly.

4.5 Voluntary participation

Researchers must ensure that participation in research is on a voluntary basis. Researchers will explain to participants in clear, age-appropriate language that participants are not required to participate in the study, and that they may stop participating in the research at any time. Researchers will carefully explain that refusal to participate will not result in any negative consequences. Incentives may be provided; however, researchers must ensure that these would not induce participants to participate where doing so may cause harm.

4.6 Informed consent

At the start of all data collection, research participants will be informed of the purpose and nature of the study, their contribution, and how the data collected from them will be used in the study, through an information and consent form, where possible and where this would be appropriate and not intimidating for young people. The information and consent form should explain, in clear, age appropriate language, the nature of the study, the participant's expected contribution and the fact that participation is entirely voluntary. Researchers should talk participants though the consent form and ensure that they understand it. Where possible and appropriate, parents / carers should also sign an 'information and consent form'. The needs for this will depend on the age and capacity of participants. Where possible, parental consent should be obtained for all children aged under 13 years. For children aged over 13, the decision on whether consent from parents / carers is needed will be made on a case-by-case basis, depending on the nature and context of the research and the age and capacity of participants.

Where it is not possible for the participant to sign an information and consent form (e.g. due to illiteracy), researchers will explain the nature and purpose of the study, the participant's expected contribution, and the way the data they contribute will be used, and request the verbal consent of the participants to conduct research and then record that permission has been granted. Special effort must be made to explain the nature and purpose of the study and the participant's contribution in clear, age-appropriate language. Researchers will request the participant to relay the key information back to them to ensure that they have understood it. Participants will also be advised that the information they provide will be held in strict confidence (see below, 4.6).

Special care must be taken to ensure that especially vulnerable children give informed consent. In this context, vulnerable children may include children with disabilities or children with learning difficulties or mental health issues. Informed consent could be obtained through the use of alternative, tailored communication tools and / or with the help of adults that work with the participants.

4.7 Anonymity and confidentiality

Ensuring confidentiality and anonymity is of the upmost importance. The identity of all research participants will be kept confidential throughout the process of data collection as well as in the analysis and writing up study findings. The following measures will be used to ensure anonymity:

- Interviews will take place in a secure, private location (such as a separate room or corner or outside space) which ensures that the participant's answers are not overheard;
- Researchers will not record the name of participants and will ensure that names are not recorded on any documents containing collected data, including on transcripts of interviews and focus group discussions;
- Researchers will delete electronic records of data from personal, unprotected computers;
- CCLC will store all data on a secure, locked server, to which persons who are not employed by the Centre cannot gain access. All employees of the CCLC, including volunteers and interns, receive a criminal record check before employment commences; and
- Research findings will be presented in such a way so as to ensure that individuals are not able to be identified.

All participants will be informed of their rights to anonymity and confidentiality throughout the research process. Participants should be informed where it is possible that their confidentiality will be compromised. This may occur where, in a particular, named setting, the background information relating to a participant may make it possible for them to be identified even where they are not named.

4.8 Addressing child protection concerns

During the data collection process (e.g. in individual interviews and also possibly group interviews), participants may disclose information that raises child protections concerns (i.e. information indicating that they are currently at risk of or are experiencing violence, exploitation or abuse). Prior to the data collection taking place, researchers should be provided with copies of the child protection policies and procedures of each institution from which participants are recruited (i.e. schools, community groups, detention facilities) and should familiarise themselves with child protection referral mechanisms and child protection focal points.

In the event that the child interviewee reveals that they are at high risk of ongoing or immediate harm, or discloses that other children are at high risk of ongoing or immediate harm, the researcher will prioritise obtaining the child's informed consent to report this information to the appropriate professional as set out in the child protection policy, or, in the absence of such a policy, the person with authority and professional capacity to respond. If the child declines, the researcher should consult with an appropriate designated focal point, as well as the lead researcher and other key persons in the research team (on a need to know basis), concerning the appropriate course of action in line with the child's best interests. If a decision is made to report this information to the designated professional, the child interviewee is carefully informed of this decision and kept informed of any other key stages in the reporting and response process.

In some cases, it will be more likely that child protection concerns may arise. Where this is the case, Researchers should ensure that research is carried out with a social or support worker who is able to give assistance and advice to the participant where necessary.

4.9 Ensuring the physical safety and well-being of researchers and participants

Researchers must ensure that data collection takes place in a safe environment. Participants will always be interviewed with at least two persons present (two researchers; one researcher and one translator; one researcher and a social worker; or one researcher and a note taker).

Researchers will be provided with a Code of Conduct, attached to each contract of employment.

ANNEX C: Findings at a glance

Laws which influence access to SRH services		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influence of law**
Consent to medical treatment	Sri Lankan statutory law does not contain specific provisions in relation to young people's ability to consent to medical treatment (including to access SRH services). However a general circular no. 01-25/2015 issued by the Ministry of Health and Indigenous Medicine provides that Adolescent Sexual and Reproductive Health (ASRH) services may be provided to a minor under the age of majority (18) irrespective of parental consent, if it is likely that the minor will engage in sexual intercourse which will be 'detrimental' to their physical or mental health without the provision of the service.	Service providers interviewed in the qualitative research generally expressed the view that children and young people have the right to access SRH services and that there is no legal or policy barrier to the provision of services to these groups, though a majority of service providers in the survey stated that they are only legally able to provide access to SRH services to a minor after an assessment of the young persons capacity. By contrast, most young people reported that there are legal restrictions on minors' access to SRH services: the majority of respondents who believed that there is a legal age for access to SRH services believed this to be 18 years. When asked why a person had to be 18 to access SRH services, however, young people tended to justify this view in terms of social and cultural norms rather than direct legal barriers.
Abortion	Section 303 of the Penal Code establishes that 'causing a woman to miscarry' is illegal and subject to up to three years' imprisonment and/or payment of a fine. If the woman is 'quick with child' causing a miscarriage is subject to imprisonment up to 7 years, and a fine. Section 306 further states that any act preventing a child to be born alive or causing a child to die after its birth is punishable with imprisonment of up to 10 years. Finally, causing a miscarriage without a woman's consent is subject to punishment with imprisonment for a term, which may extend to 20 years, and a fine. Penal Code s303 also makes clear that these provisions would also apply to a woman who causes her own miscarriage. The only exception provided by the legislation is if the miscarriage was case "in good faith", in order to save the life of the mother.	All respondents interviewed in the qualitative research were aware that there are general legal prohibitions on abortion in Sri Lanka. While the majority of service providers were aware of the specifics of the legal provisions – that abortion is legal when it is necessary to save the life of the mother – most young people and parents had limited knowledge and understanding of the specifics of legal provisions concerning abortion, and reported simply that abortion is both illegal, and unacceptable according to social and religious norms. Not only is the almost absolute prohibition on abortion in Sri Lanka a direct legal barrier to young people's access to abortion services: it functions as an indirect barrier by solidifying the taboos and shame associated with sexual activity amongst young people, especially in a context where having a baby outside of marriage is deeply stigmatised.

Laws which influence access to SRH services		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influence of law**
Sex reassignment surgery	The legality of sex reassignment surgery in Sri Lanka is unclear as no comprehensive national policy or guidelines exist.	The lack of legal framework for sex reassignment surgery makes it effectively impossible for transgendered or intersex individuals to be legally recognised according to their gender identity and also limits their ability to access sex reassignment surgery.
Sexual and Reproductive Health Education (SRE)	There is no legal provision providing for free and universal sexual and reproductive health education in Sri Lanka. The government of Sri Lanka has articulated intentions to improve the quality and coverage of adolescent sexual and reproductive health education, however.	SRE in schools in Sri Lanka appears to be insufficient and inconsistent, often because teachers are resistant to teaching it (often due to pressure from parents). As a result, many young people who participated in the research were poorly informed about sexual and reproductive health. Not only does lack of SRE constitute a direct barrier to young people's access to education services, it creates indirect barriers to access to other services; without education young people lack knowledge and information about the services that are available to them or how to access these services. A legal requirement to provide comprehensive SRE in schools might improve young people's access to SRE in Sri Lanka.

Laws which regulate confidential access (mandatory reporting requirements)		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influences**
Protection of confidentiality	There do not appear to be legal or professional guidelines establishing requirements that a doctor keep patient information confidential.[147]	While service providers participating in the qualitative research tended to maintain that they would protect young people's confidentiality in practice, both survey respondents and qualitative interviewees appeared confused and uncertain about the law on this matter. Data from the study indicates that the majority of children and young people do not consider themselves to have a legal right to confidential access to SRH services. Lack of legal protection of confidentiality serves as an indirect barrier to access because where young people don't feel their privacy will be protected, this increases the shame and embarrassment associated with accessing services.

[147] *It is very possible that such guidelines do exist, but we were unable to identify or obtain them in this study.*

Laws which regulate confidential access (mandatory reporting requirements)		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influences**
Reporting requirements	General circular no. 01-25/2015 published by the Ministry of Health and Indigenous Medicine establishes that reporting requirements under section 21 of the Code of Criminal Procedure Act do not imply a legal duty on health care workers to report to authorities if they learn that a person under the age of 16 is sexually active.	Service providers appeared to view reporting requirements as discretionary – a position which is consistent with the circular. Young people and parents, particularly in Batticaloa, were aware that young persons who were found to be sexually active could be reported to child protection services and face legal repercussions, the most extreme of which involved being placed in a care centre ('probation centre'). This (perception of the) application of reporting requirements serves as an indirect barrier to young people's access to SRH services.

Laws which regulate confidential access (mandatory reporting requirements)		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influences**
Age of marriage	The Marriage Registration Ordinance (1908) sets the minimum age of marriage at 18 years for both men and women. The marriage Registration Ordinance does not apply to the Muslim community; no specific age of marriage is set out in the Muslim Marriage and Divorce Act 1954.	The majority of respondents were aware that there is a minimum age of marriage, although some reported (incorrectly) that the age of marriage for girls is younger than the age of marriage for boys. The legal minimum age of marriage influences young people's access to services: young people, as well as parents appeared to believe that sex related services are not available to young people who are not yet married. This implies that minimum age of marriage laws may serve as an indirect barrier to access to services for 'underage' adolescents.
Statutory rape/minimum age of sexual consent	The minimum age of sexual consent is established in the Penal Code Amendment Act 1995 to be 16 for both boys and girls. *The Penal Code Amendment Act establishes a lower age of sexual consent for girls who are married – 12 years of age.*	Most respondents were aware that the law establishes an age below which it is illegal for a person to have sex, and that sex with a person under this age is a criminal offence. Most participants (incorrectly) believed this age to be the same as the minimum age for marriage. Statutory rape and minimum age-based sexual assault laws were found to influence young people's ideas about the age at which it is acceptable to be sexually active and therefore to access SRH services.

Laws which regulate confidential access (mandatory reporting requirements)		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influences**
Rape and sexual violence over 18	Section 363(a) of the Sri Lankan Penal Code defines the crime of rape as non-consensual sex with a woman even where she is his wife (as long as they are judicially separated). In other words, marital rape is not legally prohibited in Sri Lanka. Section 365(b) of the Sri Lankan Penal Code also criminalises sexual abuse of male and third sex individuals, thought this is not defined as 'rape' within the law. Section 363 of the Sri Lankan Penal Code provides that evidence of resistance (of rape) is not needed to prove that sex was non-consensual, however, in the case of Kamal Addararatchi v. State, the Supreme Court upheld a ruling that victims of rape must show evidence of struggle to prove a lack of consent.	Overall, research findings demonstrated that while respondents were aware that sexual and domestic violence are prohibited in law, these forms of violence occur with impunity. No respondents in the qualitative research described a scenario (hypothetical or real) in which a man would be held legally accountable for physically or sexually abusing his wife, which is consistent with the law.
Criminalisation of same sex sexual activity	Section 365(a) of the Sri Lankan Penal Code provides that 'gross indecency' between two persons is criminalised and punishable with imprisonment of up to two years or with a fine, or both, under the Penal Code (Amendment) Act 1995, section 365 (a) – this provision is generally understood to apply to same-sex sexual activity.	Despite the fact that legal provisions criminalising same sex sexual activity are reportedly no longer implemented in practice, many young people, including members of the MSM and transgender community, held the belief that both same-sex sexual activity and sex reassignment are illegal. Criminalisation and lack of recognition reinforce the stigma associated with alternative sexual behaviours and gender identities and create significant barriers to accessing services. Individuals who engage in criminal acts may fear disclosing information about their sexual activity to service providers due to fear of prosecution. Criminalisation and lack of recognition also place LGBT groups at greater risk of discrimination, extortion and violence, due to their lack of legal protection.

Laws which regulate confidential access (mandatory reporting requirements)		
Area of law	**Sri Lankan Provision**	**Knowledge, perceptions and influences**
Criminalisation of sex work	While sex work in Sri Lanka is not explicitly criminalised, the Penal Code provides that a woman who engages in street sex work may be subject to arrest, detention and conviction under the Colonial Vagrants Ordinance 1842, section 7 which criminalises soliciting in a public pace *"for the purpose of the commission of any act of illicit sexual intercourse or indecency"*.	Legal criminalisation of sex work reinforces the shame and disempowerment of women who sell sex and reduces their likelihood of seeking services. Sex workers included in the study were accessed through a support organisation that works in particular with sex workers and provides with basic SRH services, however their responses suggest that they would be unlikely to see other services elsewhere.

Disclaimer:

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