Submission to the Universal Periodic Review of Sri Lanka

Submitted by **Mannar Women's Development Federation (MWDF)** and the **World Organisation against Torture (OMCT)**

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I. Introduction

1. This submission focuses on reproductive violence, in particular on Female Genital Mutilation (FGM), forced sterilization and the lack of control over contraception, obstetric violence, child marriage, the criminalisation of abortion, the lack of gender-sensitive transitional justice mechanism, the lack of mechanisms for emergency situations, and the lack of sex education[1].
2. During the third UPR cycle, Sri Lanka had received and accepted a recommendation on reproductive rights, (take "all legislative and political measures as needed to guarantee universal access to sexual and reproductive health, according to the Plan of Action of the Beijing Conference") and had accepted 6 recommendations asking Sri Lanka to address gender-based violence. As shown in this submission, Sri Lanka has not implemented those recommendations.

II. Female Genital Mutilation

3. FGM is a form of gender-based violence against women (GBVAW) and girls and a form of torture[2]. This practice which is known as "female circumcision", is colloquially referred to as "*sunnat*" or "*khatna*". For a long time, the practice remained largely undetected in Sri Lanka. For example, the World Health Organisation (WHO) reported a "zero-score" for FGM in Sri Lanka in a report on gender-based violence in 2008, echoed by the UNICEF's national report card on essential indicators relevant to maternal and child health in Sri Lanka since 2005 that stated instances of FGM have remained at nil. A 2008 joint Ministry of Health (MoH) and WHO report on violence and health in Sri Lanka stated that FGM "does not exist in Sri Lanka"[3].
4. It is only since 2016 that the practice of FGM received public attention in Sri Lanka[4]. Women affected by the practice have begun advocating for State intervention to protect children likely to be harmed. Confidential submissions were made to the Human Rights Commission of Sri Lanka, the National Child Protection Authority of Sri Lanka, the Sectoral Oversight Committee on Women and Gender of the Sri Lanka Parliament, and the Women's Caucus of the Parliament of Sri Lanka[5]. In response to this advocacy, the MoH issued a circular to all medical professionals highlighting the potential harm and prohibiting the practice[6]. Medical professionals also responded to religious resistance in public debates on the subject by introducing clarity and medically accurate information[7].
5. Women who are the victims of FGM also face patriarchal discrimination from family and community members[8]. For a substantial period, Muslim women have faced ostracization, expulsion, threat, and sometimes violence from within their communities for demanding their rights – particularly rights in relation to family law reform and addressing GBVAW, including domestic violence[9]. All within the broad social and political context that women in Sri Lanka face, including discrimination, failure to respond to the violence they have faced, and failure to secure administrative and legal measures to secure their rights[10]. As such, FGM is a difficult concern to raise or publicly advocate against within families, communities, and within the current political context.

a. Scope and Scale of FGM in Sri Lanka

6. FGM in Sri Lanka falls within the WHO classification Type 1, which refers to the partial or total removal of the clitoral glans and/or the prepuce or clitoral hood, and Type 4, which includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area[11]. A majority of those affected appear to have experienced the Type 4 form of FGM of a nick, scrape, pinch, or slight cut to the clitoris or thereabouts. Victims of this practice are new-born girls, or girls at seven days, nine days, 15 days, or 40 days after birth. Consequently, victims have no memory of the procedure[12]. A minority of those affected described a more serious Type 1 form of FGM. Young girls of the Dawoodi Bohra community around the age of seven are reported to

have experienced Type 1. Anecdotal information also suggests that adult women are subject to the practice as a ritual associated with being accepted as Muslim[13].

7. The prevalence of FGM has not been systematically studied. The practice is observed as mainly prevalent amongst the Muslim communities of Sri Lanka. Approximately half of the Muslim population consists of women and girls, amounting to close to 5% of the Sri Lankan population. From within this, owing to a diversity of ideological and sociological factors, the practice varies from group to group and sometimes from place to place within the country[14]. Geographically, this means that areas within provinces in which there are significant Muslim populations, such as the Central, Eastern, Northwestern and Western Provinces, are most likely to see FGM observed[15].
8. The practice is institutionally promoted by the All Ceylon Jamaiyathul Ulema (ACJU), the Center for Islamic Studies, Young Muslim Men's Association Conference, and United Religions Initiative[16]. In the case of the Dawoodi Bohra community it is believed to be mandated by their leadership. In response to women complaining about the practice, these groups advocated medicalization as opposed to an outright ban. At the level closest to the practice, FGM is protected, promoted, and carried out mainly by women in the communities. Most often mothers, grandmothers, and mothers-in-law have been described as insisting on the practice being continued. The practice is carried out by "*Ostha Mamis*", who are medically untrained female traditional practitioners, and sometimes by licensed medical practitioners[17].
9. The two cases below are illustrative of how FGM is practiced in Sri Lanka:
   Faiza is often told by her grandmother that her tomboy like behaviour has to do with her not being adequately tamed. She was 12 years when she first heard this phrase from her grandmother. It took another 10 years for her to understand what was done or partially done to her body. She comes from a middle-class Muslim family and while she was reading for her degree she read an article in a newspaper about FGM. She discussed with her fellow classmates, and she was shocked to learn that all four of her friends belonging to the Islamic faith, including a close friend belonging to the Bohra community, have undergone Sunnat. Faiza was scared to ask her mother about the details. She still remembered what her grandmother used to say. She approached her aunt for an explanation, who told her that everyone in her family had undergone Sunnat. Her aunt told her that the ritual was performed on her in their house when she was 30 days old, but, that her father had stopped it halfway through since Faiza cried a lot. The Ostha Mami was given her payment and sent off and no one in her family knows whether she was properly cut. Hearing this shocked her and to date she has had no conversation with her parents on this even though she decided to address this issue in her social media postings[18].
10. Anusha was 26 years old when she underwent FGM. She fell in love with a Muslim man who is her best friend's brother and decided to convert to Islam. She was a Hindu by birth and left her family after she married her Muslim boyfriend. A few weeks after their Nikkah (wedding) ceremony her sister-in-law (who is also her best friend) took her to a barber woman (Ostha Mami), saying that she is not fully Muslim until this ritual is performed. Anusha (now called Fathima) was also told by her husband's family that she cannot bear a child without Sunnat being done to her. Fathima knows Muslim men undergo Sunnat but never knew this was done to women as well. She could not resist anything because she had abandoned her family and the only family left is her husband's, thus, she agreed. She still remembers the trauma and how she was held tightly by her sister-in-law and two other women while Ostha Mami slit her clitoris with a blade. She bled and they put some talcum powder on it. She remembers not being able to walk afterwards and feeling faint while her husband's family celebrated it and gifted her with jewellery[19].

b. Limitations of the Legal Framework

11. The practice of FGM is not expressly criminalized. However, in accordance with the Penal Code, it is possible for FGM to be treated as an offence under Section 308A relating to

cruelty of children and Sections 310 and 311 relating to harm and grievous harm. However, due to women's limited access to justice, their limited trust in the police and judiciary, extreme delays in investigation and adjudication, and low conviction rates,[20] express provision for the offence is necessary.

12. Although a group of women made a submission in December 2017 to the Minister of Justice to introduce specific language to criminalize FGM, there has been no response to date. The demand sought to expand the definition of grievous harm in the Penal Code (Section 311) to include practices that "excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of another person", subject to certain medical exceptions[21]. This measure would need to keep in mind the secretive nature of the practice and the perceived ties between practice and culture, which may need to be specifically addressed as part of policy on this law reform.

c. Lack of Access to Reproductive Health and Rights Information and Services

13. There is a lack of access to family planning and reproductive and sexual health services and education for many girls and women. Affected communities are particularly vulnerable to this shortcoming due to women not having access to the limited services available either due to control exerted within families or due to fear of discrimination by State sector service providers. Since most affected women belong to the Muslim minority, there are fears of being further marginalized.[22] These challenges have not been addressed by government or non-governmental organizations. State agencies have failed to improve accessibility and promote community health services that recognize and address FGM and equip women with relevant information.

III. Forced Sterilization and Lack of Control over Contraception

14. The lack of safe sex education, affordable and accessible contraception, the stigma surrounding sex and sexuality of women, the criminalization of abortions, and the significance given to "virginity" drives women and girls to resort to risky, sometimes fatal, measures in attempts to avoid having children they were not prepared to have or did not consent to having. The lack of agency, knowledge, and literacy to make informed decisions often leads women to be coerced or compelled into sterilization.
15. Forced sterilization affects mostly tea plantation workers of Tamil ethnicity, a minority historically persecuted and discriminated against. Since the privatization of plantations in 1992, the primary concern of maximizing profit resulted in the exploitation of female plantation workers, particularly their reproductive rights. Field research conducted in Tamil plantation communities found cases of forced sterilizations, with 97 cases reported within a period of 10 years[23].
16. In the plantation sector, welfare officers promote family planning proactively due to the acute poverty. Interviews the author carried out with women concerned, community leaders, and a doctor revealed that men are reluctant to undergo vasectomy procedures and instead force their wives to undergo sterilisation treatment. It happens that doctors opt for caesareans when delivering babies from disadvantaged women so that it is possible to perform a sterilisation procedure at the same time, following consent from the child's father. Any medical procedure involving a woman's womb requires her husband's consent. This also means that women who by their own will want to undergo sterilisation procedures are unable to do so without seeking and gaining this consent.
17. Sri Lanka does not have comprehensive regulations on informed consent for sterilization, with the only requirement being a consent form signed two weeks prior to the procedure. It was found that most plantation workers would sign the form mere hours before the procedure[24]. To the knowledge of the author, none of the victims have received any form of redress for this wrongdoing.

18. It has been recognized that forced sterilization is a form of torture[25]. The HRC, along with the CAT and CEDAW, have made it clear that such practices need to be prosecuted and perpetrators punished.

IV. Obstetric Violence

19. Misinformation and the prevalence of cultural ideologies also result in a variety of obstetric violence, understood as the mistreatment that occurs during the care provided during pregnancy, childbirth, or the immediate postpartum period[26]. Women reported of experiencing verbal or emotional violence by care providers during childbirth, including being accused of "messing up" the labor room by delivering a baby, being told they could not afford proper clothes but afford to get pregnant[27]. There are also reports of physical violence, such as slapping on a woman's hand during childbirth for accidentally touching the midwife[28]. Victims of obstetric violence commonly believe that reacting to abuse or lodging a complaint could have negative implications for their babies[29].
20. Obstetric violence also occurs in the form of hymenoplasty and episiotomy stitches, otherwise known as "husband stitches". There are Colombo-based "cosmetic medical clinics", such as London Antiaging, that advertise hymenoplasty procedures in mainstream media and social media campaigns as sexual enhancement procedures[30]. There are also reputed hospitals, such as Durdens, offering hymenoplasty procedures, citing reasonings ranging from "forgetting the past", a "gift" for "a special occasion" or the "night of their marriage", and "cultural beliefs". The episiotomy stitch or the "husband stitch", is sometimes performed by doctors without the consent or knowledge of women following vaginal birth. The stitch is intended to create tightness for the increased pleasure of male sexual partners post vaginal birth and/or tearing[31].
21. Obstetric violence intersects with cultural, racial, and religious discrimination[32]. Studies have found that obstetric violence is mostly experienced by Tamil and Muslim women and women of disadvantaged socio-economic backgrounds. There are particularly strong Sinhala nationalist movements in Sri Lanka[33]. and space for Muslim communities is shrinking34. Although anti-Muslim sentiment is nothing new, the situation has regressed significantly in recent years. Incidents of violence against Muslims committed with impunity have become more frequent[35.. This also affects Muslim women when in delivery rooms, where they are verbally and physically abused as previously described[36].

V. Child Marriage

22. The Muslim Marriage and Divorce Act (MMDA), which regulates marriages, does not contain an absolute minimum age for marriage. Section 23 provides that "a marriage contracted by a Muslim girl who has not attained the age of 12 years shall not be registered under this Act unless the *Quazi* for the area in which the girl resides has […] authorized the registration of the marriage". Not only does this law explicitly permit marriage of girls as young as 12, but it also allows that even younger girls can be forced to marry if authorized by a Muslim magistrate (a *Quazi*)[37]. Moreover, the MMDA makes marriage registration optional. Hence many child marriages are unregistered and complete prevalence of the practice is therefore unknown.
23. It is estimated that about 12% of Sri Lankan women who are between 20 and 24 have been married before the age of 18[38]. It is further estimated that numbers increased since 2020 as a result of the pandemic. With schools being closed for months, many families decided to take the opportunity to marry their daughters off[39].
24. There has been continued resistance to reform the MMDA. Religious leaders have argued that increasing the age of marriage for girls to over the age of 18 would allow premarital sex and children born out of wedlock. This perspective suggests that Muslim women are sexualized

from a very early age and that reproduction is the key reason for marriage[40]. Unsurprisingly, there have been instances in which girls were forced to marry their rapists in order to prevent shame and restore the honor of the girl's family, particularly when the victim was pregnant[41].

25. Child marriage threatens the lives and futures of girls and women and makes them more vulnerable to further violence[42]. It is a form of reproductive violence. Child marriage threatens the lives and futures of girls and women and makes them more vulnerable to further violence[43]. Child marriage is often accompanied by early and frequent pregnancies which result in high maternal morbidity and mortality rates[44].
26. Because of its detrimental effect for girls' mental and physical health and potential threat to life, the CAT and Special Rapporteur on Torture have found that child marriage amount to torture or cruel, inhuman, or degrading treatment[45].

VI. Criminalization of Abortion and Unsafe Termination of Pregnancies

27. Archaic legislature, such as laws concerning abortion, have prevailed since 1883. The existing abortion law not only restricts women's right to abortions but also criminalizes the act. Section 303 of the Penal Code provides that anyone voluntarily causing a pregnant woman to miscarry is subject to up to three-years imprisonment and/or payment of a fine, unless it was caused in good faith to save the women's life. Under this law, doctors and women who induce their own miscarriage are subject to the same penalties[46]. It has been cited as one of the strictest abortion laws in the world[47]. Given the lack of alternative regulated mechanisms and care, women and girls are forced to resort to means that are unsafe and sometimes fatal[48]. In 2016, the MoH reported that 658 unregulated abortions were performed daily, being the second or third top causes for maternal mortality[49]. In an interview with the International Planned Parenthood Federation, Sonali Gunaseka, Director of Advocacy at the Family Planning Association of Sri Lanka, stated that the mortality rates for unregulated abortions stands at approximately 15%, due to complications resulting from unsafe conditions as well as a lack of necessary aftercare[50]. Another grievance, which poses a challenge when seeking necessary care, is caused by the threat of prosecution for unplanned and/or unwanted pregnancies.
28. All parties involved in the abortion process may face criminal charges, which makes finding safe services particularly difficult, especially for low-income families. Even in cases of medical examination and aftercare for rape cases in Sri Lanka, the procedure can be incredibly invasive, prejudicial, and retraumatizing, as survivors are profiled and often directly or indirectly blamed for the assault.

VII. Lack of Gender-sensitive Transitional Justice Mechanism

29. Sri Lanka has a long and complex history of ethnic tensions between the Sinhalese majority and Tamil minority that resulted in a prolonged civil war between the Liberation Tigers of Tamil Ealam (LTTE or the Tamil Tigers) and the Sinhalese dominated Sri Lankan government. The LTTE fought to create an independent Tamil state in the Northeast of Sri Lanka due to continuous discrimination and violence against the Tamils. The conflict has resulted in serious human right violations under international humanitarian law by all parties, including arbitrary arrests, extrajudicial killings, disappearances, displacement, use of child soldiers, torture, ill-treatment of persons in detention, and GBVAW[51]. The impact of the armed conflict on women has been felt in several different ways. Many female heads of households from ethnic and ethnoreligious minority groups in areas affected by the war experience high rates of poverty, unemployment, and are vulnerable to violence[52].

30. Many studies conducted on Sri Lankan women's reproductive concerns in conflict affected areas found higher levels of poverty, higher rates of early marriage, pregnancy, home births, maternal mortality, lower levels of early contraceptive use and depletion of reproductive healthcare services in the North and East of the country[53]. There has been no accountability as of yet for these grievances, violations, and acts of violence enacted against women and girls despite the countless documented cases, reports, and testimonials brought forward after the war ended. Gross negligence and mistreatment by authorities has rendered victims and survivors with no support, no services, or State mechanisms to address their issues[54].

VIII. Lack of Gender-sensitive Mechanisms for Emergency Situations

31. During the many years of conflict, the situations of displacement, the natural disasters, like the Tsunami, and now the pandemic and economic crisis, the State did not have a response mechanism catering to women and girls' needs and vulnerabilities[55]. This is despite the increase of sexual assault, forced marriages, unwanted pregnancies, child marriages, spread of sexually transmitted infections, trafficking, sexual slavery, and abuse being overwhelmingly common during crisis situations, such as conflict situations or emergency situations, like the post-tsunami period, when many cases of sexual violence were reported,[56] and the current governance and economic crisis.
32. "Woman to Woman" was a training program requested by the Sri Lankan Women's Coalition for Assisting Tsunami Affected Women (CATAW) and developed by the UN Population Fund. CATAW identified and documented key issues experienced by women while developing responses to issues. The coalition cited a lack of services, infrastructure, appropriate health and medical services, female healthcare providers, female police officers, resources, such as sanitary products, safe spaces, and security arrangements for women and girl's specific issues. They also highlighted a lack of healthcare resources and services essential during prenatal and post-natal periods, and for childcare. The heightened vulnerabilities during crisis situations, restricted mobility, and limited access to services further victimizes survivors of violence. Women's needs remain unaccounted for in disaster and crisis situations[57]. In a country that has normalized negative sexist socio-cultural ideologies and practices, Sri Lanka also lacks the necessary State-implemented policies and interventions to ensure that women and girls' specific needs, such as their sexual and reproductive rights, are met specially in the context of current medicine, food and fuel shortage and lack of political will to look at food security though women's perspectives. The same can be said for the plight of Sri Lankan women in the current Covid-19 pandemic, during which a multitude of sexual and reproductive health rights violations increased [58] and women were forced to work in conditions that exposed them to Covid-19, particularly in over-crowded garment factories where a third wave of Covid-19 just started.

IX. Lack of Sex Education and Public Awareness

33. The State, as the entity that has sworn to protect its citizens, has a responsibility to rectify mainstream discourse, to take the necessary measures to dissolve rape culture that shifts the blame on survivors rather than the perpetrators, and the notion of girls and women being "responsible" to prevent and resist assault. However, sex education in Sri Lanka is inadequate[59]. Although the solution seems self-evident, measures taken by civil society have been terminated at every juncture. The textbook entitled "*Hathe ape potha*", which details safe sex practices, was banned by the State, while grade 11 health books horrifically state that unwanted pregnancies occur due to women and girls "acting out of their feelings instead of rational thinking"[60]. It blames survivors of sexual assault for their experiences and villainizes

persons with mental health issues by branding them sexual predators. The provision of safe sex education that is inclusive of important components, such as consent, compliance, coercion, reproductive health and rights, pleasure, exercising bodily autonomy, sexually transmitted infections, and contraception, would make a huge difference in equipping individuals to make informed decisions regarding their bodies.

X. Recommendations:

34. Criminalize FGM.
35. Prohibit the use of sterilization without the prior, free and informed consent of the person concerned, and ensure that such legislation is effectively implemented
36. Take measures to protect women's rights to safe motherhood and access to appropriate obstetric services, and investigate and prosecute cases of obstetric violence
37. Set the minimum age to marry at 18 years in all relevant laws including the MMDA
38. Amend relevant legal provisions to decriminalize abortion
39. Strengthen measures to ensure access for girls, adolescents and women, including those living in rural areas, to adequate sexual and reproductive health services, including modern contraceptive methods family planning, abortion and post-abortion services
40. Ensure effective access to justice for all women victims of violence during the conflict, in particular reproductive violence, including adequate reparation
41. Investigate well documented cases of sexual violence during war and in the aftermath of the war through an international justice process
42. Ensure the participation of women at all stages of the peace process in national reconciliation and all reconstruction initiatives, as well as in transitional justice processes, in particular at the decision-making level
43. Increase participation of women in decision-making position and management of natural disasters and emergency situations, particularly in the current economic crisis;
44. Declare services related to reproductive needs and GBVAW as essential services in a crisis situation.
45. Make sex education compulsory in schools

[1] The report is based on primary and secondary data, most of which has been published by the same authors in Women Break the Silence. Gender-based Torture in Asia, OMCT and PAHRA, May 2022, https://www.omct.org/site-resources/legacy/Gender-based-Torture-in-Asia.pdf.

[2] See e.g. CAT, *Concluding Observation on Congo*, UN Doc. CAT/C/COG/CO/1, May 28th 2015, para. 20; Human Rights Council, *Resolution on the Elimination of female genital mutilation*, UN Doc. A/HRC/RES/44/16, July 24th, 2020, para. 13.

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[12] Ibid.
[13] Ibid.
[14] Ibid.
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[16] In September 2018, these groups made joint representations to the Parliamentary Oversight Committee on Women and Gender demanding the withdrawal of a circular preventing medical professional carrying out FGM (Daily Mirror, *Muslim groups call for female circumcision to be medicalised*, September 7th, 2018, http://www.dailymirror.lk/article/Muslim-groups-call-for-female-circumcision-to-be-medicalised-155186.html). In 2018, the Centre for Islamic Studies in Sri Lanka criticized the government after the health ministry denounced FGM and prohibited doctors from any involvement in the practice (Banerji, Annie, *Sri Lankan Islamic center condemns ban on female circumcision as 'affront'*, Reuters, July 12th, 2018, https://www.reuters.com/article/us-sri-lanka-women-fgm-idUSKBN1K12OZ).
In 2008, the ACJU of Sri Lanka issued a fatwa on "female circumcision", saying it is obligatory and recommended, citing religious teachings as well as the view that circumcision is important to maintain cleanliness of the genitals and 'for enjoyment in family life' (Fatwa on Female Circumcision Ref 005/ACJU/F/2008).
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