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Research Seminar: "Rights Protection for the Vulnerable and Marginalised: Perspectives from the Region"

Organized by
Faculty of Law, University of Colombo and Institute of Human Rights and Peace Studies (IHRP), Mahidol University

Friday, 29 June 2018, 09.00-12.30
Faculty of Law, University of Colombo

Seminar Program

Time	Activity	Remarks
09.15 – 09.30	Registration	
09.30 – 09.45	Welcome and Introductions	
09.45 – 10.05	The galvanization of temiars' activism for self-Determination: a case study of the application of the UNDRIP in Malaysia - Koong Hui Yein (Malaysia)	
10.05 – 10.25	Rights to be heard and privacy of an offender child: a study of Sri-Lanka – Madhu Bilas Neupane (Nepal)	
10.25- 10.45	Discussion Discussant 1: Ms. Danushka Medawatte Discussant 2: Dr. Rose Wijeysekera	
10.45 – 11.00	Break	
11.00 – 11.20	The policy and legal context in relation to adolescents right to HIV testing in Sri Lanka – Hettiarachchige Niluka Dilshan Perera (Sri Lanka)	
11.20 – 11.40	The Condition of Poor Female Patients' Access to the Primary Level Health Care Facilities in Bangladesh – Ashma Rahman (Bangladesh)	
11.40 – 12.00	Discussion Discussant 3: Dr. Naazima Kamardeen Discussant 4: Dr. Prasanna Cooray	
12.00 – 12.30	Time of questions and answers (for all participants)	

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The Condition of Poor Female Patients' Access to the Primary Level Health Care Facilities in Bangladesh

***Ashma Rahman* [1]**

Institute of Human Rights and Peace Studies (IHRP), Mahidol University, Thailand and Centre for the Study of Human Rights (CSHR), University of Colombo, Sri Lanka

Abstract

Bangladesh since independence achieved much progress in public health domain, but the rich and the politically blessed can extract major services from the public health system. Evidence shows that significant numbers of women patients in local health care center in Bangladesh are facing multi-level discrimination, which constitutes clear violation of their right to health. Such discriminations against women patients are reflected in massive corruption, financial exploitation, negligence and misbehavior by the appointed health care providers, practitioners and the doctors at the primary level health care centers. In this context the objective of the paper is to contextualize the access of right to health by the poorer women patients in local health care center. The research identifies the forms of discrimination those constitute the violation of the 'right to health'. A qualitative method was adopted for this purpose. The research applies 'Human Rights Based Approach' in its analysis and generated its data from interview. The discriminatory acts of the healthcare providers against poor women patients clearly breach the rights to health mentioned in the Bangladesh Constitution and Article 25 of the UDHR, 1948. The discriminatory attitude is not only due to the status of the patients but also their gender dynamic. Since most of the poorer population access the local healthcare centers the doctors and medical practitioners do not take them seriously and due to the absence of a proper monitoring system the sufferings of the poor female patients remain unaddressed. There is also a presence of psychological domination of the medical practitioners over the poorer women patience. Thus, this research describes that the poor women healthcare seekers in the local healthcare center are subject of multiple levels of discrimination.

KEY WORDS: Right to Health/Women Patients/Discrimination/Local Health Care Center.

I. Introduction

Bangladesh, despite its steady growth in economic development, is still away from ensuring the proper access for its people to all sectors of public services. The

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[1] [1]Ashma Rahman is a Master's student of the Institute for Human Rights and Peace Studies at Mahidol University. She completed her Bachelors of Science in Psychology from Chittagong University, Bangladesh. Her thesis research is about analyzing the poor female patients' access to the primary level health care facilities in Bangladesh.

country is still facing significant challenges due to its high population, environmental hardship, chronic poverty, poor governance and cultural inconsistency. Thus, the healthcare system has not reached to its ideal stage. The legal and policy measures concerning healthcare service are gradually getting shaped, but the functioning of the healthcare administration is causing discrimination against a certain section of the society. Those who are lagging behind concerning economic status are yet to be functionally constituted as the inclusive part of the service receiver at the primary level healthcare center by the healthcare providers. Moreover, if the healthcare service seeker would be a female with lower socio-economic background then the chance of her being neglected and being exploited become much higher (Mahmud et. al. 2004). These discriminatory phenomena constitute violation of poor female patients' entitlement to healthcare. The causes of such obstacles to access the health care services by the poor female patients are often linked with various socio-cultural factors, economic reasons and approaches of the service providers (Hamiduzzaman et.al. 2016). The problematic and limited 'access' of the female patients at the primary level healthcare center not only breaches the legitimate right to health of the poor female patients but also the country's commitment to ensure equal and non-discriminatory healthcare services for all.

Thus the paper considered the existing problematic access situation at the primary healthcare centers significant enough to analyze. The paper investigated the challenges within the healthcare service center in accessing the services and also the ways and the extent of those challenges that affect the access of the poor female patients to the service. This eventually allowed the understanding about the state of right to health of the poor female patients at the primary level healthcare facilities in Bangladesh.

II. Right to Health and Access

Right to health is one of the basic human rights. Right to Health is defined as "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 1986). The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966) incorporated right to health (Art. 12) as one of the important human rights that the state needs to ensure for all. The Committee on Economic, Social and Cultural Rights' (CESCR) General Comment 14 on the Right to Health particularly mentions the accessibility of health as an important element of the fulfillment of the health right. Ensuring the access to quality healthcare is a very important aspect for protecting and fulfilling the health rights of the people. Within health care, "access" is always defined as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs (Whitehead, 1992). Access to healthcare services needs at least two components to participate: the care providers and the care receivers. If these two entities—the providers and the receivers—are not dedicated or aware to provide or receive the services, access to healthcare becomes problematic. When the access to healthcare services are interrupted or hindered, the meaningful realization of right to health becomes difficult to achieve. One of the core

reasons for such interrupted or hindered access is the presence of discrimination in the healthcare service setting. The convention prohibits the discrimination in terms of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status (ICESCR, 1966) in accessing the healthcare services. Although Bangladesh is a signatory country to all relevant international treaties ensuring right to health, given to the reality of the socio-cultural context and the existing administrative malpractices, it still cannot establish a non-discriminatory access to the primary healthcare facilities for its large number of poor female patients. Ferdaush and Rahman (2011) claimed that the situation of female patients is very poor as they face multi-level of discrimination at the healthcare service centers. According to the findings the access of a poor female patient to the treatment is so hard that if she goes to the healthcare centers without any male person she will hardly get any attention from the hospital staff. The researchers also claimed this limited access due to discrimination based on gender and socio-economic factors in turn affect the health standard of poor female patients as this vulnerable section of population do not have any other suitable alternative for the treatment (Ferdaush et.al. 2011). Thus the discrimination in accessing the healthcare services at the primary level healthcare centers results violation of the poor female patients' right to heath.

III. Gaps between Policies and Practices Complicating the Access

The present healthcare system in Bangladesh is found to be not being able to provide the adequate and proper access to some very needy and vulnerable section of people such as poor female patients due to improper application of the rules and policies (Rahman 2006). The role of the state by the existing healthcare policies in the provision of health rights is to ensure minimum care to every individual. This obligation includes the respect, protection, promotion and fulfillment of the right of health of every single citizen of the country. Being a signatory state to most of the international treaties that include health right, Bangladesh's constitutional provisions have been made to protect, respect and to promote individual as well as collective rights in the society. The healthcare service system has also formed with an aim to stick to its constitutional commitment of ensuring an equal and no-discriminatory health care system. But the reality at the ground is unfortunately somewhat dissimilar with the commitment on the paper. And this reality has been found in the many researches that have been conducted at the very ground level of healthcare system. Such kind of gaps between policies and the existing practices reflected in the presences of widespread corruption in the healthcare sector.

Transparency International (2009) found that the health sector is the second most corrupt sector after the police sector in Bangladesh. These kinds of malpractices in the healthcare sector make the proper and equal access extremely difficult especially for those who do not have the capability to meet up the financial demand of the healthcare service providers such as poor female patients. As a result, the presence of corruption

severely limits the opportunities for the poor patients to get a free and equal access. The victims of such malpractices are mostly the poor female section of the patients due to their vulnerabilities. Killingsworth (2009) in his research confirms that the widespread collection of unofficial fees at various level health facilities is a common form of rent seeking behavior among the healthcare providers which is mostly done with the female patients who visits the healthcare centers alone. This epidemic and unchecked corruption in the public health care system is completely contradictory with its healthcare policies and this indeed seriously complicated the access of poor female patients to the primary level healthcare facilities.

IV. Challenges in Accessing the Health Care Services in Bangladesh

The healthcare facilities and the practices of the healthcare provider are yet to reach the national commitments for ensuring healthcare for all iterated in various national health policies. However, crucial element of discrimination is to do with the attitude of the healthcare providers that particularly challenges the equal and adequate access for poor female patients. There are hardly any government documents that accept the presence of attitude problems of the healthcare provider. However, several academic works as well as NGO reports suggest that the challenge of non-discriminatory access to the healthcare service in Bangladesh is due to the lack of proper attitude of the healthcare providers towards poor female patients and this improper way of dealing with the vulnerable section of the patients indeed constitutes serious violation of their right to health. Such violation often results in problematic access for the vulnerable section of patients. Islam et.al (2009) found in their research that the level of the complexities in accessing the healthcare system actually affect people differently according to their educational and financial background. That means in the service the less educated, poor and rural people are more vulnerable to get affected by the disparities that are present there. This is quite a big challenge for keeping the commitment of ensuring equal access to the healthcare facilities for all. Thus the paper adopted a qualitative approach where the main source of data is the primary data in order to obtain in-depth information of the real scenario.

V. The Condition of Access

The paper found that the presence of corruption and lack of monitoring and the lack of accountability of the perpetrators are enduring the complex troublesome access of the poor female patients in the healthcare service. As it has been conceptualized through the international human rights instruments, the adequate access to healthcare is a vital element for realizing the right to health; any acts or components against such access is the breach of the right to health. Given to the reality of the healthcare centers at the rural area the findings points out the deficits factors for such an inadequate access for the poor female patients in particular. The functional dynamics of the deficit factors indeed correspond with the long-rooted partiality of the societal context in which the selected healthcare center is situated.

The factors within the healthcare center and the surrounding socio-cultural antecedents altogether found to be making the access of the poor female patients so

complicated that it even causes the complete exclusion of the poor female service seekers from the very legitimate healthcare facilities. The functional dynamics of the deficits factor corruption is found to be creating discrimination among the service seekers. And the victim of such complex interplay of widespread corruption and the influencing partial and patriarchal societal settings is none other than the poor female patients. Due to the vulnerabilities of them in the society and the inefficiency, lack of education and overdependence this section of the population silently tolerates all the exploitation occurred with them. The findings particularly reveal that the same kind of ill practices and the exploitation affects the different kind of service seekers differently. And in this case it affects the vulnerable poor female patients most adversely. On the other hand those who are empowered and conscious of protecting against the violation are found to be affected very little through the improper functional mechanism. They even sometimes get the benefits of existing corruption by availing extra services by fulfilling the undue financial demand. This irresponsible approach by the wealthy section of the patients in turn aids the corrupt service providers to gain personal benefits. Unfortunately this large benefitted section does not care about the ongoing sufferings of the poor female patients. As a result the struggles and sufferings for accessing the very basic healthcare facility by of the poor vulnerable women continue without any concern of monitoring.

Thus from the findings, few key points have been evident regarding the presence of the deficits factors. Firstly, the mere presence of this component of corruption indeed prohibits the access of the poor female patients either complete or partially. Thus the existence of this deficiency within the gatekeeping mechanism resulted in excluding the service seekers. Furthermore, the nature of the ill component facilitates the other similar ill components; negligence and discrimination to become interrelated which in turn make a severe complexity for the access of the poor female patients, which significantly limits it. Finally, due to the characteristics and the nature of its mal functioning, corruption considerably gives raise and facilitates the discrimination to make the access condition problematic by impeding it to a significantly greater extent.

The complexity caused by the widespread practice of discrimination created further predomination of neglecting the right to health. All of these in turn basically hindering the proper access of the poor female patients making the conditions more complicated for them. Thus the meaningful realization of the right to health has not been established at the primary level healthcare centers as the limited and problematic access indeed delegitimize the claim of entitlement of the poor female patients to the health right.

VI. Recommendation

It is important that the issue of access to healthcare service of the poor female patients need to be ensured not by implanting the one aspect of the process. The paper has identified that the problem has multifaceted features; so does its solution has to be in multilevel. The followings are some recommendation given in light with the responses received at the field level interview.

i) Ensuring Coordination: The coordination of healthcare service at the local level has to be ensured. To do it the local government representatives as well as the

government officials are need to be seriously engaged with the healthcare provider. Regular meeting needs to be taken place. If any parties are missing a clear initiative needs to be taken by the government officials to bring all parties.

ii) Ensuring Stakeholder Participation: Stakeholders participation one of the key element for smooth and responsive healthcare service. Patients or people representative at the local need to be regularly listened. The local representative shall also talk with the patients and get their feedback to improve the system.

iii) Enhanced Monitoring: A functional and enhanced monitoring mechanism is a must for the functioning of local healthcare service. To do it the policy requirement is to get the regular and effective monitoring of the healthcare system. It is important that the monitoring can address the corruption, logistic issues as well as presence of human personnel at the healthcare center.

At the end it is worthy to mention that the access of the poor female patients at the primary healthcare center for healthcare service is a poorly studied topic. It is not an isolated issue of any other concern in the right to health of poor female patients. However, at the surface of the challenges is the discrimination that clearly relates the right to health of the poor female patients and de-legitimization of their entitlement. Corruption, lack of medical supply, poor presence of healthcare providers and lack of institutional monitoring are common concern relates with the discrimination. At the end, these are all responsible for poor realization of right to health of the poor female patients at the primary healthcare center as these all makes the access of them tremendously complex and hindered.

Bibliography

Ferdaush, J. & Rahman. M. (2011). *Gender Inequalities in Bangladesh*. Dhaka: Unnayan Onneshan.

Hamiduzzaman .M, Bellis. D.A, Kalaitzidis. E & Abigail.W (2016). Factors Impacting on Elderly Women's Access to Healthcare in Rural Bangladesh**,** *Indian Journal of Gerontology,* Vol. *(30),* No.(2), pp. 235–260.

Islam. S.M. and Ullah. W.M (2009). "People's Participation in Health Services:A Study of Bangladesh's Rural Health Complex" Bangladesh Development Research Center (BDRC).

Killingsworth J, Hossain N, Hedrick-Wong Y, Thomas SD, Rahman A and Begum T.(2009) "Unofficial fees in Bangladesh: price, equity, and institutional issues". *Health Policy and Planning 1999,* Vol. 14: pp.152-163.

Mahmud, Simeen (2004). "Citizen Participation in the Health Sector in Rural Bangladesh: Perceptions and Reality", *IDS Bulletin,* Vol. 35, No. 2, pp. 11-18.

Rahman, M.R. (2006). "Human rights, health and the state in Bangladesh", *BMC International Health and Human Rights* 2006, vol **6**(4) doi:10.1186/1472-698X-6-4.

Transparency International Bangladesh (TIB) (2012). *Corruption in Service Sectors: National Household Survey 2012,* Available at: <http://www.ti-bangladesh.org> [Accessed 12 February 2018].

Whitehead, M. (1992). "The concepts and principles of equity and health". *International Journal Health Service* ;22:429–445. doi: 10.2190/986L-LHQ6-2VTE-YRRN.

World Health Organization (WHO). (1986). *The Constitution of World Health Organization.* Geneva: WHO.

The Galvanization of Temiars' Activism for Self-Determination: A Case Study of the Application of the UNDRIP in Malaysia

Hui Yein Koong [2]

Institute of Human Rights and Peace Studies (IHRP), Mahidol University, Thailand and Centre for the Study of Human Rights (CSHR), University of Colombo, Sri Lanka

Abstract

Internationally, the concept of the right to self-determination has evolved from an understanding of gaining independence from colonial rule during the immediate post-colonial era, to a right to greater autonomy that also applies to peoples within an independent state, including a right applicable to indigenous peoples. Such a right to 'internal' self-determination enables indigenous peoples, inter alia, the freedom to use, manage and control the indigenous lands and resources. This paper aims to explore the discourses of the native customary land rights of the Temiar people in Kelantan, Malaysia under the concept of indigenous self-determination as enshrined in the UNDRIP. The author hopes to highlight the rationale behind the Temiars' claim for their right to access, use and manage their ancestral territories and the challenges entailing this struggle. The paper concludes that land rights is the utmost priority for the Temiar people at this moment and it requires efforts from all stakeholders to achieve mutual benefits for all members of the society.

Keywords: land rights, indigenous people, Orang Asli, Temiar, self-determination

I. Introduction: Indigenous Peoples of Peninsular Malaysia and the Right to Self-Determination

Numbering at only 0.6 per cent of the total population of Malaysia, the Orang Asli has played a significant role in shaping the history of the country. Prior to 1960, the indigenous peoples of Peninsular Malaysia were generally known as 'aborigines' in English

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[2] Hui Yein Koong is a Master's Student in Mahidol's University Institute for Human Rights and Peace Studies. She received her Bachelor of Arts in Economics under the London School of Economics and Political Science International Programme in 2012. She has been working with the Indigenous Peoples Network of Malaysia (*Jaringan Orang Asal SeMalaysia*, JOAS) as a Project Manager prior to her studies in Mahidol University. Her thesis research is on the application of the UNDRIP in Malaysia by examining the Temiars' activism for self-determination.

literature and addressed condescendingly as 'Sakai'[3] or 'Jaccons', 'Biduanda', and was introduced as a friendlier term during the Emergency Period of Malaya[4] between 1948 and 1960 when the British realised that winning the hearts and minds of the Orang Asli was a crucial strategy in winning a war against the communists who had developed contact with the Orang Asli while operating the guerrilla warfare in the forests of Malaya.

The Orang Asli are not a homogenous group, but their cultural markings are based on the ancestral lands that have been passed down generations upon generations. There are 18 subethnic groups in the Peninsular including the Temiar people. Their history, language and customs have been developed within these specific ecological niches—a trait shared by most, if not all Orang Asli, as captured by the following statement:

> On these traditional territories, the Orang Asli possess extensive and holistic traditional knowledge of the biological resources found therein. Such knowledge can only have been acquired if they had lived and retained control of the traditional territory for a very long time. Equally important is the fact that over this traditional territory, the Orang Asli exercise autonomy and control. This is their manifestation of 'self-determination' (Nicholas, Engi and Teh, 2010: 23-24).

The authors recognised that the above statement may appear to be 'highly romantic' of the Orang Asli and there may be Orang Asli who has forgotten of their roots or left their ancestral lifestyle either by choice or assimilation to mainstream culture. But there are equally many Orang Asli who still maintain exclusive communities, speak their own languages, practice customs according to an *adat* or customary law, and practice their own systems of leadership and governance. It follows then that they are entitled to the right of self-determination (Nicholas, 2010: 64).

The concept of indigenous peoples' self-determination is laid out in Article 3 and Article 4 of the UNDRIP as follows:

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[3] 'Sakai' is a term with varying derogatory connotations including meanings of 'slaves', 'dependants', 'subjects', etc. with origin from the Sanskrit word '*sakhi*' which means 'friend'; suggesting that Hindu traders were interacting with the indigenous people as early as seventh century (Nicholas, 2000: 69).

[4] The Federation of Malaya was a federation administered by the British colonials that existed from 1 February 1948 until 16 September 1963. The Federation became independent on 31 August 1957 and was merged with Sabah (North Borneo) and Sarawak Crown Colonies to form Malaysia in 1963.

> Article (3)—Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development;
>
> Article (4)—Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

In principle, the right to self-determination incorporates certain inalienable rights of the indigenous peoples on account of their prior presence on the land. Moreover, this principle reflects the concept of the "internal self-determination" which calls for the freedom and autonomy in political, economic, social and cultural affairs in relation to their ancestral domain within the state. It differs from the concept of "external self-determination", as pointed by Eagleton (1953), that demands international responsibility with a membership at the UN which ultimately means secession or the recognition of a new state.

In the context of the Orang Asli, the right to self-determination would generally include, but not be limited to: (a) the right to the ownership of their lands as the territorial base for the existence of their populations; (b) the right to use, manage and dispose of all natural resources found within their ancestral lands; (c) the right to control their own local economies, and the right to economic prosperity; (d) the right to restore, manage, develop and practise their culture, language, traditions and way of life in accordance with their worldview, and to educate their children to them; (e) the right to determine the form of self-government, and to uphold their own indigenous political systems; and (f) the right to a life of peace and security (Nicholas, 2010:65).

In sum, the indigenous peoples' right to self-determination has evolved from a concept of statehood during the post-colonial era to a right connected to the decisions of using, managing and controlling of indigenous lands and resources (Subramaniam and Nicholas, 2018).

II. Temiars' Indigenousness is Linked to Land

As of 2018, the Temiar population in the state of Kelantan is 11908; which is 12 per cent of the total population of Kelantan, or 0.0004 per cent of the total national population

of Malaysia (Syed Hussain P.R., et al. 2017: 42). Being one of the 18 sub-ethnic groups recognised in Peninsular Malaysia, the Temiars have their own distinct language and culture. This distinct cultural identity is a result of the specific ecological niche that has developed generations over generations within their customary bounded territories. These bounded territories and customs or taboos within these spaces are vital for their survival and peacekeeping among the Orang Asli.

The ancestral domains of the Temiars are generally known as the *saka*. And within the *saka*, there are areas such as: (a) *Teiq wei/teiq neiwei/pendraq*—a previous hamlet or site where they no longer live or hunt due to poor harvests, poor hunting opportunities, or where an incident in the area caused them to move out, e.g. a devastating flood (*na-deg*); (b) *Teiq chareq*—areas where the land is not fertile for crops; (c) *Teiq keramat*—sacred areas, where spirits have their abode, where people are not allowed to hunt or fish. This includes certain pools in the river which may have bountiful stocks of fish; (d) *Teiq jendrap*—areas where blood was spilled (as in where a tiger had killed a man); (e) *Teiq selumbang*—the abode of water dragon (*naga*); usually swampy areas or large pools of water where the water is reddish in colour, the colouration being so due to the red faeces of the dragon. Also associated with a sewang ritual/song that is performed to avoid the bah merah (red flood); and (f) *Teiq nemdep*—areas in the forest where the hunting rights belong to specific families with no overlapping claims. Others may enter the area but they cannot hunt or set traps there without permission from the owners of the hunting grounds (SUHAKAM 2013: 30-31).

The land, especially the jungle, and along with the rivers, mountains and animals within it, "constitutes essential knowledge of their rights" (Subramaniam, 2016: 79). Therefore, during the conduct of interviews for this research, the researcher consistently heard the term *hak* (meaning "right" in the sense of entitlement, as opposed to *tanah* which means land) being used especially by the elderly, including those who have not been to UNDRIP training or workshops. The following is a quote from Tatak Abas in the Cawas Blockade[5]:

> This is the problem because the state government destroyed our *hak*, the logging has polluted our rivers, our forests, our livelihoods; how can we live?

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[5] An anti-logging blockade set up by the Temiars since 2016. The blockades were demolished several times by loggers and Forestry Department, but the Temiars persisted and had rebuilt the blockades several times.

> That's our life. That's why we are doing this blockade. We are blockading our *hak* (interview at Cawas Blockade, 30.5.2018).

III. Temiars' Losing Land

As of 2017, out of the supposedly 129,000 hectares—while it is believed that the actual figure is 645,000 hectares (*Free Malaysia Today* 02.07.2013)—Orang Asli land, the land that has been gazetted as Orang Asli Reserves are 32,700 hectares (*Free Malaysia Today*, 7.12.2017). None of these belongs to the Temiars in Kelantan. This fact turns Kelantan as the one out of the nine states in Peninsular Malaysia with Orang Asli population without a single Orang Asli Reserves. It is speculated that the non-recognition of Orang Asli lands is because of the fact that most of the Orang Asli in Kelantan are residing in the last natural frontiers of the state. Logging is, at the moment, a primary income for the Kelantan state government (Kelantan Forestry Department, JPNK, 2018). Therefore, it is easy to see why has the state government made no effort to secure the rights of Orang Asli to their ancestral lands.

The non-recognition of the Temiars' right to their ancestral domain is one of the main strategies employed by the Kelantan State Government to control their resources. With that, the state government were able to lease out large tracts of land to private companies under the name of poverty-reduction programmes by having a state-run plantation project. On 27 April 2006, the Ladang Rakyat or 'People's Farm' Corporation was established to manage the opening of land and the plantations. The '*modus operandi*' of the Ladang Rakyat is to lease out state lands to companies on a 99-year contract to be developed, either into oil palm plantation or latex timber clone plantation (LTC).

At least 81,095 acres of land, including land in the Gua Musang Region, had been leased out in 2011 under the Ladang Rakyat project (National Audit Department, 2011: 76). Recently, part of the Permanent Reserved Forest amounting to 199,352 ha, had been zoned as a potential plantation area for LTC. That is a vast area and the map shown in the report has revealed that the proposed LTCs are indeed on top of the Temiars' land. All these plans were carried out without adhering to the principle of Free, Prior and Informed Consent (FPIC) as explained in Article 10 and Article 11 of UNDRIP. There are so many incidents that villagers were taken by surprise when they saw logging or plantation companies entering their community. One of the interviewees, Pak Alek from Pos Balar has revealed the non-compliance to FPIC by the Kelantan Forestry Department:

> (Kelantan) Forestry Department [they] enter (the ancestral territories) without considering the presence of the village headman. They thought that we are only tenants. Then, they just entered straight away. They enter the primary forest without consulting us. They just continued their work. When asked by us, they say this is permission from the state government; they allow us to work…and so the logging came (interview at Pos Balar, 2018.05.30).

FPIC has not been codified into domestic laws in Malaysia. However, it is a requirement in many certification bodies such as the Roundtable for Sustainable Palm Oil (RSPO)[6] and Malaysia Timber Certification Council (MTCC). In March 2016, MTCC has announced publicly about the suspension of its certification for the Kelantan State Forestry Management Unit (i.e., Forestry Department) until further notice[7] (MTCC, 2016).

It is mandatory for trees located in logging areas to be selected, tagged and catalogued under the National Forestry Act 1984. However, these practices are slowing down the loggers who want to make quick bucks. The state government have aided the process of bulldozing and clearing the land for logs by circumventing the Act by exercising its power provided in Article 74(2) of the Federal Constitution which gives states priority jurisdiction over land matters including the forest. Many experts have attributed the massive floods that have hit Kota Bharu—the capital of Kelantan—and Gua Musang to the excessive land clearing activities in Gua Musang region (*New Straits Times*, 17.1.2017).

IV. The Land Paradox: State vs Federal

When these issues were brought to the Chief Minister's office through memorandum submissions or meetings called by the JKOAK, all stakeholders face difficulties to come to terms.

In Malaysia, the land is a state matter pursuant to the Federal Constitution of Malaysia in which the supreme law of the country prescribes two-tier governmental structure that is the Federal and the State Government. Land law and administration are

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[6] Criterion 2.3, 7.5 and 7.6 of RSPO Certification and Principle No.3 of the MTCC Certification elaborate how FPIC should be carried out in the situation where the plantation area or logging concession overlap with native lands.

[7] The suspension of the *Certification for Forest Management* for Kelantan FMU is still in force until today.

based on the Torrens System introduced by the British where Register is everything. Therefore, a land is state's land unless titled and given other directives.

The National Land Code ss the main land law that is used in Peninsular Malaysia[8]. Despite the authority lies upon the state government when it comes to matters of land, Article 76(4) of the Federal Constitution does give authority for the Federal Government to make laws pertaining to tenure, acquisition, transfer of land, and other rights and interests in land. Besides, Article 91 of the Constitution also shows that the National Land Council can provide directives or act to recognize and protect the Orang Asli customary lands, vis-à-vis Article 8(5) of the Constitution which permits the Federal Government to legislate for the 'protection, well-being and advancement' of the Orang Asli, including 'the reservation of land'. To date, no directives have been given out from the National Land Council pertaining to the reservation of Orang Asli lands.

In Kelantan, the then Chief Minister blamed the Department of Orang Asli Development (JAKOA) for not doing the land surveying work which has caused the problem of land encroachment and destruction in Orang Asli areas (COAC, 20.2.2011). This blame-game is easy to be put up because JAKOA is an agency under the federal government and therefore the Kelantan government could point fingers to each other for being unable to carry out the surveying job.

When confronted with demands to recognise the land rights of the Temiars, "there is no *tanah adat* or 'native customary land' in Kelantan," said the then Deputy Chief Minister, Datuk Ahmad Yakob (*Harakah Daily*, 6.3.2012). The then-Chief Minister once stated that "as long as the local authority had not conducted the perimeter survey and placed the demarcation stones, and the Land Office had not issued the land title, the land belonged to the state government," when he was denying claims that the state government is taking away land from the Temiars (BERNAMA, 26.5.2011). The state government is not keen to recognise the rights of the Temiars to their native customary land. However, the recent judicial development in Kelantan, or nationally, tells a different story.

V. Judicial Development in Malaysia

Although Malaysia inherited the Torrens System from the British, the country's judiciary has also picked up the common law system. Having applied jurisprudence on the survival of indigenous laws and customs from other common law jurisdictions for around a

[8] Sabah and Sarawak is governed by Sabah Land Ordinance and Sarawak Land Code respectively.

decade, the Malaysian superior courts and finally, the apex court of Malaysia, namely, the Federal Court recognized the legal continuity of the pre-existing customs and interests of indigenous peoples in respect of ancestral and customary lands in 2007.

2007 marks the year when the apex court of Malaysia (the Federal Court) recognised the legal continuity of the pre-existing customs and interests of indigenous peoples in respect of ancestral and customary lands through the *Sagong Tasi* case (Subramaniam and Edo, 2016: 87).

In this case, Sagong Tasi along with 23 family heads from Bukit Tampoi in Dengkil, Selangor had 38.4 acres of their land taken away from them for the construction of the Nilai Banting highway to link with the new Kuala Lumpur International Airport in 1995. The compensation paid was paid nominally based on the value of the fruit and rubber trees instead of the value of the land. After a long battle from the Selangor High Court to the Court of Appeal, the judges held that the Orang Asli rightful holders of their ancestral land in which their "customary ownership, original title and usufructuary rights to the land are not destroyed, restricted or extinguished". Besides, the judges also held that the Selangor State Government and JAKOA, the agency of the Federal Government have the fiduciary duty to protect the welfare of the Orang Asli and the land and are, therefore, holding the land as trustees for them" (The Malaysian Bar, 2002).

The common law system implies that any legal pronouncements by the Federal Court are binding and form part of the "law"—a provision under Article 160(2) of the Federal Constitution of Malaysia. Besides, one of the characteristics of common law is such that reference can be made to a case under the jurisdiction of the same system. In *Sagong Tasi*, the judge commented that the decision was "influenced by the persuasive authority of the Canadian Case of *Calder v. A-G of British Colombia*…and the Australian cases of *Mabo & Ors v. State of Queensland & Anor* … and *Pareroultja & Ors v. Tickner & Ors*." All these cases are related to indigenous people's land rights cases and were applied in Malaysian courts[9].

In Kelantan, two communities, i.e., Pos Belatim and Pos Balar have brought their cases to the Kelantan High Court to seek justice when their ancestral lands were given away

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[9] Another landmark case is the *Adong bin Kuwau* case in 1997. In this case, 52 *Jakuns* (or Jaccons) were awarded compensation by the Johor High Court when after the state government took the forested land and leased it to the Public Utilities Board of Singapore to build a dam to supply water to Johor and Singapore. The case was significant when the judge has granted the *Jakuns* the right to their "roaming areas" including the forests.

by the state government to a private contractor to start the *Ladang Rakyat* plantation. They were the first who filed a case against the *Ladang Rakyat* Project. Pos Belatim first filed their case in 2011 and Pos Balar in 2015. Both of them are neighbouring communities and were equally affected by the *Ladang Rakyat* Project. They first tasted victory when Pos Belatim won their case at the High Court in April 2017, which 9,300 hectares of their ancestral territories are recognised in court and *Ladang Rakyat* cannot be carried out in these areas.

The consent settlement for the Pos Balar case includes: (1) recognition of settled and cultivated areas of the Temiars to be their customary lands; (2) these areas will be gazetted as Permanent Orang Asli Settlement under Section 62 of the National Land Code while land titles will be given to these areas under Section 43 of the same code; (3) the surrounding forests will be declared "Protected Forests" with no logging permitted but the Temiars are allowed to enter and use these forests for their customary practices and subsistence (COAC, 14.4.2018).

This consent judgement was a huge relief for the Temiars and the lawyers as the previous judgement of *TR Sandah*, a case in the state of Sarawak on January 2017 at the Federal Court did not grant the customary rights of the Dayaks to freely access the forest for food, medicines and such like. However, the lawyers of *Balar* and *Belatim* case managed to counter that by stating that the peninsula refers to *Sagong Tasi* case as the apex pronouncement. However, despite the positive development in the courts, it is still an uphill battle for the Temiars as the trend in recent years is such that the highest court of the land tries to overturn these judgements (COAC, 2018).

VI. Conclusion: Securing Temiars' Land and Resources

As shown so far, the Temiars' right to their ancestral territories are provided in the Federal Constitution and also by the courts. The Temiars will not have their rights to their ancestral land secured without efforts from the Kelantan State Government. The political will for the Kelantan State Government to gazette land for the Temiars is hampered by the need to secure income for the state from the rich natural resources within the Temiars' land. Therefore, the newly formed Federal Government[10] has the responsibility to convince or ensure the Kelantan State Government to secure the land rights of the Temiar people. There

[10] After 61-year of ruling by *Barisan Nasional*—the same coalition since gaining independence in 1957—the Federal Government is now run by a new coalition, i.e. the *Pakatan Harapan*. The 14th General Election was held in May 2018. However, the ruling political party in Kelantan is not part of *Pakatan Harapan*.

should be concerted efforts by the Federal Government to put pressure onto Kelantan State Government. This can be done by working legal and field experts and also civil society groups to provide strong support for the Temiars' struggle.

However, one of the possible reasons that actions are not taken fast enough by the Federal Government is the worry of setting precedents for other state governments, and this requires coordinated consents from all states before making any significant decisions for the Temiars. Human Rights Commission of Malaysia (SUHAKAM), Malaysia Bar Council and Centre for Orang Asli Concerns (COAC) have advised to make law reforms and review existing government agencies in favour of securing land rights for the Orang Asli including the Temiars. The missing link now is the political will of the Kelantan State Government, or perhaps the people in Kelantan in general.

Malaysians lack the understanding of the Orang Asli issues as information is not widely available on mainstream media and syllabus. Therefore, the movement should include educating the people of Kelantan of the plight of the Temiars and how can they be seen as equals in the state instead of as a group of people "living a backward life in the jungle". It is understood that logging is one of the main incomes for the Kelantan State Government along with other natural resources, but there are other ways for the state to earn income by preserving these natural resources such as ecotourism and value-added forest product in which the Temiars can play a role as partners in these industries.

Temiars' indigenousness is linked to land and this relationship cannot be replaced by "development" defined by the mainstream population. The right to access, use and manage their ancestral territories is the utmost priority for the Temiars. In this age of fighting climate change and environmental disasters caused by modern human activities, the indigenous people's knowledge and value hold the key to secure humanity and environment. Moreover, most of all, the spirit of democracy can only be continued when a society is inclusive and different culture can exist harmoniously accompanied by mutual respect and understanding. Therefore, we should stand for the Temiars and work with the Temiars.

BIBLIOGRAPHY

Anaya, S. James (1996). *Indigenous peoples in international law*. Oxford University Press, New York.

Asian Human Rights Defenders (2012). Orang Asli protest alleges Kelantan gov't land grab. *AHRD*. [Online] Available at: <https://asianhrds.forum-asia.org/?p=3864>[Accessed 2 July 2018].

Barume, Albert Kwokwo (2010*). Land Rights of Indigenous Peoples of Africa*. IWGIA Document No.115, IWGIA, Copenhagen.

Cheng, N. (2016). Kelantan Can't be Forced to Gazette Land for Orang Asli, says Low. *The Star* [Online] Available at: <http://www.thestar.com.my/news/nation/2016/10/06/ball-is-in-state-govts-court-kelantan-cant-be-forced-to-gazette-land-for-orang-asli-says-low/>[Accessed 25 March 2018].

Clifford, N. (2017). *Why are some First Nations leaders resisting the UNDRIP*? Maclean's. [Online] Available at: <https://www.macleans.ca/opinion/why-are-some-first-nations-leaders-resisting-the-undrip/>[Accessed 2 July 2018].

COAC (2011). *Ladang Rakyat 'development' activities*. Center for Orang Asli Concerns, Subang Jaya. [Online] Available at: <https://www.facebook.com/notes/center-for-orang-asli-concerns-coac/ladang-rakyat-development-activities/202542696456331/>[Accessed 22 February 2018].

Court: 9,300 ha must remain Orang Asli customary land (2017). *Free Malaysia Today* [Online] Available at: <http://www.freemalaysiatoday.com/category/nation/2017/04/23/court-9300ha-must-remain-orang-asli-customary-land/>[Accessed 22 February 2018].

Dessanti. C. (2014*).* Indigenous Peoples' Right to Self-Determination in International Law. *Intra Vires* 1.1, pp. 45-55.

Dr Sr Wan Nor Azriyati Wan Abd Aziz & Assoc Prof Dr Sr Noor Rosly Hanif (2012). *Land Administration in Malaysia*. 17th ASEAN Valuers Association Pre-Congress. [Online] Available at: <http://aseanvaluer.org/images/PDF/Land%20Administration%20in%20Malaysia.pdf>[Accessed 22 February 2018].

Eagleton, C. (1953). Excesses of Self-Determination. *Foreign Affairs*, Vol.31, No.4, pp.592-604. [Online] Available at: <https://www.jstor.org/stable/20030992>[Accessed 2 July 2018].

Human Rights Commission of Malaysia (2013). *Report of the National Inquiry into the Land Rights of Indigenous Peoples*. Kuala Lumpur: SUHAKAM.

Lasimbang, J. et al (2015). *Red & Raw: Indigenous Rights in Malaysia and the Law*. Jaringan Orang Asal SeMalaysia, Penampang, pp. 62.

MalaysiaKini (2012). Kelantan Orang Asli slams MB, Demand Apology. *MalaysiaKini* [Online] Available at: <https://www.malaysiakini.com/news/195563/>[Accessed 26 September 2017].

MTCC (2016). *Suspension of Forest Management Certificate for Kelantan State FMU*. Malaysian Timber Certification Council. [Online] Available at: <https://mtcc.com.my/suspension-of-forest-management-certificate-for-kelantan-state-fmu/>[Accessed 12 July 2018].

New Straits Times (2017). "Confusion" led to inclusion of Orang Asli land in Ladang Rakyat Project. *New Straits Times*. [Online] Available at: <https://www.nst.com.my/news/nation/2017/04/234415/confusion-led-inclusion-orang-asli-land-ladang-rakyat-project>[Accessed 4 October 2017].

Nicholas, C. (2000). *The Orang Asli and The Contest for Resources: Indigenous Politics, Development and Identity in Peninsular Malaysia*. International Work Group for Indigenous Affairs (IWGIA), Copenhagen; & Center for Orang Asli Concerns (COAC), Subang Jaya.

Nicholas, C. (2010). *Orang Asli – Rights, Problems & Solutions*. Human Rights Commission of Malaysia (SUHAKAM), Kuala Lumpur.

Nicholas, C.; Engi, J. & Yen Ping T. (2010). *The Orang Asli and the UNDRIP, from Rhetoric to Recognition*. Center for Orang Asli Concerns (COAC), Subang Jaya.

Nicholas, Colin (2014). *Outsiders in Their Own Land*. Center for Orang Asli Concerns, Subang Jaya, Malaysia. [Online] Available at: <https://www.facebook.com/notes/center-for-orang-asli-concerns-coac/outsiders-in-their-own-land/830520956991832/>[Accessed 2 July 2018].

Nordin, R. & Witbrodt M. A. (2012). Self-Determination of Indigenous Peoples: The Case of the Orang Asli. *Asia Pacific Law Review*, 20:2, pp 189-210.

Roseman, M. (1998). "Singers in the Landscape: Songs, History and Property Rights in the Malaysian Rainforest." *American Anthropologist* 100(1), pp.106–21.

Sagong bin Tasi & Ors v Selangor & Ors [2002] 2 MLJ 591.

Subramaniam, Y. & Edo J. (2016). Common Law Customary Land Rights as a Catalyst for the Resurgence of Orang Asli Shamanism in Peninsular Malaysia: Some Lessons from the Semai and Temiar Peoples. *Shaman*, Vol.24 No.1 & 2, pp.72-94. International Society for Academic Research on Shamanism, Budapest, Hungary.

Right to be heard and right to privacy of an offender child during the law enforcement and court proceedings in Colombo, Sri Lanka

Madhu Bilas Neupane [3]

Institute of Human Rights and Peace Studies (IHRP), Mahidol University, Thailand and Centre for the Study of Human Rights (CSHR), University of Colombo, Sri Lanka

Abstract

The 'right to be heard' and the 'right to privacy' of an offender child is a neglected, controversial and rarely discussed rights articulated by the International Convention on the Rights to Child (CRC). In addition to the CRC, the Beijing Rules, and the United Nations rules for the protection of juveniles deprived of their liberty (1990) discuss and provide the rights to be heard and rights to privacy. Sri Lanka is a signatory state of CRC and has a good legal framework for juvenile justice. Almost one-century-long history of the juvenile justice system of Sri-Lanka is a good example in this region. This study is being undertaken to understand Sri Lanka's experience in implementing juvenile justice, including the right to be heard and right to privacy of an offender child during law enforcement and court proceedings; with a view to disseminating Sri Lanka's learning in the region. Hence, the core focus of this research paper is to explore Sri Lanka's long history of juvenile justice system for protecting the rights of the child. The paper surveyed available secondary evidence, as well as collect primary level information from experts and stakeholders. Interviews with experts and court observation are the primary means by which the gaps in the juvenile system are discovered. And publically available documentation referred to supplement this information. Domestic legal provisions and the practices are discussed and evaluated with the reference to the international norms and standards. Date and information further analyzed through the codification and sequencing of all information.

Keywords: Juvenile offender, Juvenile court proceedings, Right to be heard, Right to privacy

[3] Madhu Bilas Neupane is a student of Master of Human Rights and Democratisation - Asia Pacific (APMA) Program in Institute of Human Rights and Peace Studies (IHRP), Mahidol University, Thailand and Centre for the Study of Human Rights (CSHR), University of Colombo, Sri Lanka. His email address is mbneupane@gmail.com and mailing address is Bharatpur 16, Devichowk, Chitwan Nepal (Contact no.: +977-9851126433).

I. Introduction

The right to be heard and the right to privacy both subjects are controversial issues and both rights are less recognized in relation to juvenile offenders. By birth, none of any child is an offender in nature but our socio-economic, cultural and other factors enforce them to stand as offender child. Their behaviors can be corrected and they can live life as a responsible adult in the future.

The International Convention on the Rights to Child (CRC), the Beijing Rules, and the United Nations rules for the protection of juveniles deprived of their liberty (1990) enunciates various rights to the child, but the right to be heard and the right to privacy is rarely discussed. In this region, Sri Lanka is a signatory state of CRC and has almost one-century-long history of juvenile justice since the introduction of Child and Young Person's Ordinance in 1939. Sri Lankan experience in implementing juvenile justice and current scenario to promote the right to be heard and the right to privacy of an offender child during the Juvenile Court proceeding is the major concentration of this study. However, the study is focusing on to find the answers of "right to be heard and right to privacy of an offender child does ensure during law enforcement and Juvenile Court proceedings in Colombo?" Similarly, stages of investigation to court proceedings in relation to the juvenile offender were the scope of the study.

The concluding observation of the CRC committee, various reports from UNICEF, and government's publications are the secondary sources of this study. Likewise, interaction with exports and observation of Juvenile Magistrate Court, Battarmulla, and Mt. Lavinia Magistrate Court, Mt. Lavinia are the primary source of this study. International mechanisms for Right to be heard and right to privacy of an offender child, Sri Lankan Legislation and institutions, discussion and conclusion are the major sections of this study.

II. International mechanisms for right to be heard and right to privacy of an offender child

In 1989 the United Nations introduced the Convention on the Rights of the Child which is recognized by 196 states as highly ratified international treaty. According to the treaty; below eighteen years human being is recognized as a child.[11]

> "laws, policies, guidelines, customary norms, systems, professionals, institutions and treatment specifically applicable to children in conflict with the law" (United Nations Office on Drugs and Crime/UNICEF, 2006, p. 54).

Through the statement, we can internalize that a child needs special treatment in all sphere. A child has various rights such as the right to non-discrimination, right to be heard, right to fair trial, right to privacy, right to legal aid, the presumption of innocence, the fixation of the minimum age of criminal responsibility etc. Among them, the right to be heard and the right to privacy is unique and provocative rights for a child.

II.A.The Right to Privacy

The right to privacy of a child is considered as very contentious and profound right; at one hand it demands protection and guidance and at another hand the child's individual autonomy (Marasinghe, 2007, pp. xxii-xxiii). Most of the international and regional instruments recognize the right of privacy as a fundamental human right. The Universal Declaration of Human Rights guided to protect from arbitrary interference of privacy[12] of any persons. Similarly, the International Covenant on Civil and Political Rights[13] as well as the Convention on the Rights of the Child[14] provide the protection to prevent from the arbitrary and unlawful interference of the right to privacy. Likewise, the European Convention on Human Rights (ECHR, Article 8), the American Convention on Human Rights (Article 11), the Cairo Declaration on Human Rights in Islam (Article 18) etc. also recognize the rights to privacy in the regional level.

[11] United Nations, Convention on the Rights of the Child, 1989, Article 1, For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.
[12] United Nations, Universal Declaration of Human Rights, 1948, Article 12
[13] United Nations, International Covenant on Civil and Political Rights, 1976, Article 17
[14] United Nations, Convention on the Rights of the Child, 1989, Article 16

Similarly, the international mechanisms and rules also provide the rights to privacy of a child to not publish his/her information (Beijing Rule No. 8.2 and ICCPR, Article No. 14.1) during all stages of the proceedings (CRC, Article No. 40.2(b)vii).

II.B.The Right to be Heard

The rights to be heard is quite interesting provisions of the CRC Article 12, which provides the opportunity to be heard for a child. As per their age and maturity, we need to provide a chance to express their views for judicial and administrative proceedings. A government has an obligation to assure the appropriate measures to fully realize the right to be heard of a child[15]. The national law will follow the procedure of law[16] to create the environment to be heard of a child. Right to be heard is fundamental for a fair trial of an offender child. A child has rights to be heard directly, through a representative or via appropriate body in all stages of the process such as investigation and court proceedings.

III. Sri Lankan Legislation

The fundamental rights section of the constitution of Sri Lanka (Parliament of Sri-Lanka, 2015) provides the rights to equality to all the citizens; through the law, all citizens have equal rights for protection and non-discrimination[17]. Likewise, the constitution has the special provision to form subordinate legislation and executive action for the advancement of children[18], the directive principles of the state policy also promotes the special care for child[19].

A basic law to deal with the child's issue is the Children and Young Persons Ordinance (CYPO) in Sri Lanka (Child and Young Persons, 1939). The ordinance introduced the provision of the establishment of Juvenile Courts, the privacy of a child along with restriction of publication of the child's identification. Similarly, as per the jurisdiction and the court proceeding process, the ordinance further divide the offenders into three categories: a. "Child", under age of 14, b. "young person", attained the age of 14 but not 16, and c. "youthful person", reached the age of 16 but not 22 years.

[15] United Nations, Convention on the Rights of the Child, 1989, Article 12, para 1.
[16] United Nations, Convention on the Rights of the Child, 1989, Article 12, para 2.
[17] The constitution of Sir-Lanka, Article 12 (1) and (2) .
[18] The constitution of Sir-Lanka, Article 12 (4).
[19] The constitution of Sir-Lanka, Article 27 (13).

The Penal Code (Amendment) 2018[20] defines the age of 12 years as the minimum age of criminal responsibility and age between 12 to14 years is a subject of maturity and understanding capacity of the child. Likewise, the Probation of Offenders Act, No.10 of 1948 describe the circumstances for probation to an offender child (The Probation of Offenders Act, 1948)[21].

IV. Sri Lankan Institutions

In relation to an offender child, the court, department of probation and child care services, police department, attorney general's department, and the prisons department execute the legislative provisions.

As per the provision of the CYPO no. 48, Part 1, Juvenile Court and Magistrate Court sitting as Juvenile Courts are the responsible for an offender child's case. In Sri Lanka, there are two specialized Juvenile Courts in existence; one is in Battaramulla and another is in Jaffna (Sunday Times, 2010). Similarly, the Department of Probation and Child Care Services is providing the correctional and supportive services to the children (Grime, 1994, p. 32). The probation officer and a child right promotion officers provide the institutional care as alternative means of protection to an offender child (Verité Research (Pvt) Ltd, 2017, p. 27). The Attorney-General's department support to prosecute crimes committed against a child in a High Court through the Child Protection Unit (Verité Research (Pvt) Ltd, 2017, p. 22). Likewise, the police department enforces the provisions of legislation related to offender child from the National Child Abuse Desk (Grime, 1994, p. 33). The prisons department provide the transportation services to the offender child from court to various institutions such as safe home, remand homes etc. (Samaraweera, 1997, p. 52).

V. Discussion

This section further elaborated on the basis of findings of interaction with exports, court observation in Juvenile Magistrate Court, Battarmulla and Mt. Lavinia Magistrate Court, Mt. Lavinia along with the available documents of legislation with reference to the international mechanisms.

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[20] Penal Code (Amendment) 2018, published as supplement to Part II of Gazette of Sri Lanka on May 25, 2018, Article 2(1).

[21] The Probation of Offenders Act, No.10 of 1948, Section No. 4 and 5.

An offender child has the right to preserve their own privacy during the law enforcement and court proceedings. No one can disclose the identification information of the child in any medium. The international standards such as Beijing Rules (Rule 8.2), International Convention on the Civil and Political Rights (ICCPR) (Article 14.1), Convention on the Rights to the Child (CRC)(Article 40.2(b)vii)) prohibit to publish the information of a child in all stages of proceedings. As the provisions of the international mechanism the right to privacy is secured by the CYPO Section 20(1) in Sir Lanka:

> "no report of the proceedings in any newspaper, magazine, or other journal shall reveal the name, address, or school, or include any particulars calculated to lead to the identification of any child or young person concerned in the proceedings, either as being the person against or in respect of whom the proceedings are taken, or as being a witness therein."

The ordinance further restricts to publish child's photographs and other information of an offended child. A statement by a state party report reveals that no any cases of violation of privacy of children and family have been recorded by the media, state, or other agents in Sri Lanka (Unicef, n.d.). Similarly, the request to get publishable information and visit in Juvenile Magistrate Court, Battarmulla and public information from the Department of Probation and Child Care Services is the subjects of approval from the Judicial Service Council. These scenario and statement are powerful to understand the Sri Lankan situation about the privacy of an offender child but the observation in courts and interview with experts disclosed the reality of violation of privacy of an offended child.

Exposure of an offender child in court premises and even in open court proceedings, a child may lose his/her right to privacy as well as right to be heard because of the abject environment. The Juvenile Court Battarmulla prohibit public to enter the courtroom during the court proceedings. However, the Court is situated on the second floor of a building, there are other offices up to the third floor. In the meantime, any people can see a child in the waiting area for any court proceedings.

Besides a courtroom, people can identify and know about the child because of his/her mobility. Similarly, in the Mt. Lavinia Magistrate Court mostly people can get access to participate in any court proceedings. But, the CYPO clearly specify the persons who can participate in the Juvenile Court proceedings: the officials and members of court, concerned

persons such as police, probation officers, attorney-at-law etc., and persons authorized by the court. Through the restriction of the public in the court proceedings helps to create a favorable environment for a child to speak out. In very few cases especially in lawyers request or judge's opinion to conduct the case in his/her chamber only the case proceed in closed court, where the public cannot get access[22]. In the Magistrate court everyone can enter during the proceedings, as a result, the media publish the details information of an offended child. Generally, Media publish all the information except the name of an offender child. As social nature of humankind, a person may be recognized by diverse ways, not only their names. The phenomenon of people's access during the court proceedings may not preserve the rights of privacy and will not help to create the rights to be heard. The legal provision only cannot preserve the privacy of an offender child but the social norms, people's mindset are very important to protect any rights.

The CRC Article 12, advocates to create a suitable environment for the rights to be heard of an offended child. As like a spirit of the CRC, the constitution of Sri Lanka ensure the rights to be heard in the Article 13(3) "Any person charged with an offence shall be entitled to be heard, in person or by an attorney-at-law, at a fair trial by a competent court." Similarly, the CYPO protect the right to be heard of a child or young persons by asking whether he/she committed the offenses or not, during the juvenile court proceedings[23]. By asking questions to a child, the court provides an opportunity to share his/her opinion in front of Magistrates. Likewise, a general comment indicated that the right to be heard and right to remain silent to an offender child during a court proceedings and law enforcement needed to secure:

> "This right of the child must be fully observed in all stages of the process, starting with pre-trial stage when the child has the right to remain silent, as well as the right to be heard by the police, the prosecutor and the investigating judge. But it also applies in the stage of adjudication and disposition, and in the stage of implementation of the imposed measures". (CRC/C/GC/10, 2007, p. 10 para 23).

The provided transportation services to an offender child by the prisons department is not child-friendly, which obstruct to maintain the privacy of a child and an unfavorable situation to protect the rights to be heard. Transporting child in prisons van revealing the

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[22] Based on conversation with Preethika Sakalsurya: Lawyer/Activist-child protection, 26 June 2018.

[23] CYPO, Article 9(5)(a) The court shall ask the child or young person whether he admits that he committed the offence.

privacy of a child, they use to collect children every day from various institutions along with prisoners for the court. After the proceedings, the child returned to his/her institutions via the same prisons van. Traveling in the city along with prisoners may affect the child's mind-set as well as he/she can lose their identity. A child may face the "Fear of public exposure" during the transportation process (Webb, 2016, p. 185). In an experience of a lawyer[24] the security personnel of prisons also used a handcuff to a child and traveled very long period in prisons vehicles. The Western Provincial Probation and Child Care Services is also planning to arrange child-friendly vehicle in near future but the vehicle will remain under the supervision of the Prison Department. According to the commissioner, the prison department cannot control an unruly child, which may not create the appropriate environment for the child.

The police, probation officer, staff of the judiciary, even judges use legal terminologies with child, which discourage a child to speak-out. The state has the responsibility to ensure the favorable environment to express an offender child's views, where a child can feel respected and secured to express his or her opinions[25].

The police, judicial and non-judicial staff are getting training from various institutions about the dealing with children but the implementation is weak. They are asking a question to a child in front of many people, dictating children with very heavy words are very common features, which may not protect the right of privacy and the environment to a child to be heard properly.

The court can use supportive instruments such as video and television to maintain the privacy of a child. Minimum use of video may promote the privacy of a child and also can empower the child to protect his/her right to be heard. However, we can be optimistic to upcoming Judicial Protection Bill in Sir Lanka for the implementation rights of an offender child.

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[24] Conversation based on 26 June 2018 with Preethika Sakalsurya, Lawyer/Activist-child protection.

[25] Committee on CRC General Comment No. 12 (2009) The right of the child to be heard, Para 23.

VI. Conclusion

The right to be heard and right of privacy of an offender child in relation to law enforcement and court proceedings is widely embedded in the domestic legislation as per the international mechanisms in Sri Lanka but the implementation of such legislation is challenging during the law enforcement and court proceedings. The transportation in police and prisons vain, information dissemination through media, unfriendly environment to a child in court are the major obstructing factors to secure the right to be heard and right to privacy of an offended child. The continuous effort to promote rights of a child in legislation and implementation indicate that the process of securing an offender child's right is in the appropriate direction. And, at least the region can learn Sri Lankan experiences of juvenile-justice system.

Bibliography

Child and Young Persons, 1939. *hrlibrary.umn.edu.* [Online]
Available at:
<http://hrlibrary.umn.edu/research/srilanka/statutes/Children_and_Young_Persons_Ordinance.pdf>
[Accessed 8 December 2017].

CRC/C/GC/10, 2007. Committee on the Rights of Children (Unedited Version). *General Comment No. 10 (2007), Children’s rights in Juvenile Justice*, 9 February, pp. 1-21.

Grime, J., 1994. *An Investivation into Children's Rights in Sri-Lanka,* s.l.: SIDA.

Hiru News, 2016. *www.hirunews.lk "Seya murder case to be heard daily from January 25th".* [Online]
Available at: <http://www.hirunews.lk/123965/seya-murder-case-to-be-heard-daily-from-january-25th>
[Accessed 24 June 2018].

Marasinghe, C., 2007. *A Child's right to privacy in international law.* 1st ed. Colombo: C R L International (Gte) Ltd.

Parliament of Sri-Lanka, 2015. *The constitution of the democratic socialist republic of Sir-Lanka.* Revised Edition – 2015 ed. s.l.:Parliament Secretariat.

Samaraweera, V., 1997. *Report on the abused child and the legal process of Sri Lanka,* Colombo: The National Monitoring Committee on the Children's Charter.

Sri Lanka: Penal Code, 1885. *National Legislative Bodies / National Authorities.* [Online]
Available at: <http://www.refworld.org/docid/4c03e2af2.html>
[Accessed 8 December 2017].

Sunday Times, 2010. *www.sundaytimes.lk.* [Online]
Available at: <http://www.sundaytimes.lk/100328/Plus/plus_10.html>
[Accessed 15 June 2018].

The Probation of Offenders Act, N. o. 1., 1948. *www.hrcsl.lk.* [Online]
Available at:
<http://www.hrcsl.lk/PFF/LIbrary_Domestic_Laws/Legislation_related_to_children/1944%20No%2042%20Probation%20of%20offenders%20Ordinance.pdf>
[Accessed 1 June 2018].

The Youthful Offenders (Training School) Ordinance, N. 4. o. 1. (., 1944. *http://hrlibrary.umn.edu.* [Online]
Available at:
<http://hrlibrary.umn.edu/research/srilanka/statutes/Youthful_Offenders_(Training_School)_Ordinance.pdf>
[Accessed 1 June 2018].

Unicef, n.d.. *www.unicef-irc.org.* [Online]
Available at: <https://www.unicef-irc.org/portfolios/documents/440_sri-lanka.htm>
[Accessed 10 June 2018].

United Nations Office on Drugs and Crime/UNICEF, 2006. *Manual for Measurement of Juvenile Justice Indicators,* s.l.: s.n.

Verité Research (Pvt) Ltd, 2017. *A Legal and Institutional Assessment of Sri Lanka's Justice System for Children,* Colombo: UNICEF.

Webb, T., 2016. Children Exposed to Violence: A Developmental Trauma Informed Response for the Criminal Justice System. *Journ Child Adol Trauma,* Volume 9, pp. 183-189.

The policy and legal context in relation to adolescents right to HIV testing in Sri Lanka

Hettiarachchige Niluka Dilshan Perera [4]

Institute of Human Rights and Peace Studies (IHRP), Mahidol University, Thailand and Centre for the Study of Human Rights (CSHR), University of Colombo, Sri Lanka

Abstract

The paper aims to discuss the rights of adolescents to access sexual and reproductive health services, with reference to the status of socio-economic rights in Sri Lanka, and specifically the status of the right to health. The paper states that in the absence of legislative provisions, a national health policy framework on sexual and reproductive health, has the potential to promote the realization of the highest attainable standard of health, as an alternative course of effective remedies. Therefore, this paper analyzes selected policies, strategic plans and circulars and identifies specific policy measures mandated by the state to facilitate the right of adolescents to access HIV testing as part of their overall right to health. The paper highlights that the existing policy frameworks does not adequately address the legal challenges faced by adolescents in accessing available HIV services such as consent requirements in case of minors. It arrives at the conclusion that despite the available data revealing the rising HIV epidemic among adolescents and young people, the current policy framework does not provide substantive measures to accommodate the complex needs of adolescents in relation to their health needs in the context of HIV. The policy framework also does not provide concrete avenues for the service providers to operate in a right to health framework which will first and foremost respect, protect and fulfill the adolescents right to highest attainable health including their right to access HIV testing and know their status.

Key words: adolescents, HIV testing, maturity, consent, right to health

[4] Niluka Perera is Master's student at the Institute of Human Rights Peace Studies at Mahidol University. He has been advocating for sexual and reproductive health of young people in Asia and the Pacific region since 2014. His thesis research is on the right of adolescents to access HIV testing and know their HIV status in Sri Lanka. His email address is nilukaperera13@gmail.com.

I. Introduction

Sri Lanka acceded to the International Convention on Economic Social and cultural Rights (ICESCR) on the 11th of June 1980. However, the Sri Lankan state has still not included Economic, Social and Cultural (ESC) rights in to the country's legislature and there is a strong local and international civil society push to recognize ESC rights as fundamental rights in the proposed new constitution (Gomez et al 2016). Chapter VI, Directive Principles, of the current constitution contains the economic, social and cultural rights of its citizens. Even though it does not specifically contain right to health, number of articles in the chapter can be interpreted to contain elements of right to health. However, article 29 of the constitution under Chapter VI specifically mentions that "the provisions of this Chapter (Chapter VI) do not confer or impose legal rights or obligations and are not enforceable in any court or tribunal" (Constitution of Sri Lanka 1978). A study done by the WHO in 2011 found that only 6 countries in the South- East Asia region guarantee the right to health as a fundamental right (WHO 2011, p. 2). It is only the constitution of Timor-Leste that mentions the particular words "Right to Health" (WHO 2011, p. 2-3). The constitutions of Bhutan, Bangladesh, India, Myanmar and Sri Lanka do not recognize the right to health as a fundamental right (WHO 2011, p. 3). In addition, in several countries in the region right to health has been recognized through successful recent amendments or constitutional reforms. Health related rights were specifically introduced in the 2007 new constitution of Thailand; a 2009 amendment incorporated right to health in to the Indonesia constitution; the Timor-Leste constitution came to power in 2002; right to health care and to relevant underlying determinants of health were included in the new Maldivian constitution which came to power in 2008; the Nepalese constitution with right to health was enacted in 2007. These developments signify the rising recognition of right to health as a fundamental human right in the South- East Asian region.

The constitutional reform process of Sri Lanka which officially began in January 2016 (The Constitutional Assembly of Sri Lanka 2016) provided an opportunity to recommend the inclusion of right to health as a fundamental right in to the new constitution. Provided the role "health" plays in the "fundamental goals of human existence", the experts recommended that health be included and enshrined as a fundamental human right in our constitution. Right to health is included in the interim-report of the Constitutional Assembly (Interim Report 2017, p. 7). However, the adoption of a new Sri Lankan constitution seems

to be far-fetched ideal provided the current socio-political context in the country. Therefore, in the absence of a constitutional right to health, the national health policy framework including national policies on sexual and reproductive health, should facilitate upholding the rights of Sri Lankan citizens to highest attainable health.

A set of key national policies in relation to health and sexual and reproductive health could be analyzed in exploring the measures undertaken by the state to respect, protect and fulfill the rights of its citizens to highest attainable health. This chapter aims to analyze selected policies, strategic plans and circulars and identify specific policy measures undertaken by the state to facilitate the right of adolescents to access HIV testing as part of their overall right to health. Article 12 of the ICESCR which refers to right to health, General Comment No. 14 of Committee on Economic, Social and Cultural Rights that expands the definition of right to highest attainable health and the article 24 of the International Convention on the Rights of the Child (CRC) which refers to right to health of children and young people will be used as a foil to analyze the existing national policies. It is also important to juxtapose the evolution of right to health in international human rights instruments with the evolution of national policy framework on health to understand the influence of international human rights instruments on the national policy framework on health. The chapter will initially provide brief overviews of the selected policies and will identify the strengthens and weaknesses of the existing policy framework and conclude with a commentary on up to which extent the existing policy framework facilitates or challenges the adolescents right to access HIV testing.

II. The Policy framework on sexual and reproductive health in Sri Lanka

The Population and Reproductive Health Policy of 1988, National Policy on HIV and AIDS in the World of Work of 2010, National HIV/AIDS Policy of 2011, National Policy on Maternal and Child Health of 2012, National Strategic Plan – Adolescent Health of 2013, National Youth Policy of 2014, National Policy and Strategy on Health of Young Persons of 2015, Circular on providing sexual and reproductive health services to adolescents of 2015, Draft National Health Policy of 2016 and the National Strategic Plan on HIV 2018 have been selected for this analysis. These polices have been selected based on their direct

linkage with sexual and reproductive health of Sri Lankan citizens in general and of adolescents and young people in particular.

The Population and Reproductive Health Policy of 1988 contains earliest references to adolescent and young people's health. The Population and Reproductive Health Policy was introduced at a specific demographic transition in the country and was aimed at reduction of the rate of population growth (Population and Reproductive Health Policy 1998, p. 3). Consisted of 8 goals, it recognizes the importance of addressing the emerging population and reproductive health issues such as safe motherhood, sub-fertility, induced abortion, reproductive tract infections and sexually transmitted diseases, promotion of responsible adolescent and youth behavior, achieving gender equality, provision of health care and welfare services to the elderly, promotion of economic benefits of migration and urbanization while controlling their adverse effects, increasing public awareness on population and reproductive health issues and strengthening the infrastructure for implementation and coordination at national and sub-national levels. Goal 4 of the policy refers to "Promoting responsible adolescent behavior". Strategy A of this goal aims to provide children and young people with information and education on "ethical human behavior, sexuality and drug abuse; strategy B aims to strengthen youth worker education by including information about drug abuse and sex related problems; Strategy C aims to encourage counseling on drug and substance abuse, human sexuality and psycho-social problems and Strategy G aims to provide legal, familial and institutional support to mothers to protect their children from sexual abuse and harassment (Population and Reproductive Health Policy 1988, pp. 3-4). The policy does not refer to the right to highest attainable health as recognized in the ICESCR to which Sri Lanka has acceded by the time of the adoption of this policy. Nor does it refer to the obligations of the Sri Lankan Government under Chapter VI of the constitution. The policy implies that adolescents need to be "cared for" and omits the recognition of the ability of adolescents in line with their "evolving capacities" as mentioned in the CRC to claim their right to health. Furthermore, the policy does not recognize the developing sexualities of adolescents and young people and refers to sex and sexualities as "problems to be addressed".

The National Policy on HIV and AIDS in the World of Work of 2010 which was adopted after the General Comment No 14 was issued by the CESCR in 2000, aims at guiding the national response to prevent HIV and AIDS, treatment care and support and

mitigate and manage its impact in the workplace, in public, private and informal sectors, while safeguarding and respecting workers' rights in line with the ILO Code of Practice on HIV/AIDS and the world of work and the ILO Recommendation 200 Concerning HIV and AIDS and the World of Work (National Policy on HIV and AIDS in the World of Work 2010, p. 6). It is one of the earliest policy documents to recognize that new HIV infections among young people are increasing (National Policy on HIV and AIDS in the World of Work 2010, p. 3) and also one of the earliest documents aiming to protect the fundamental human rights of all people as enshrined in the Sri Lankan constitution (National Policy on HIV and AIDS in the World of Work 2010, p. 6). Even though the policy does not contain any specific references to adolescents and young people, the fact that it has recognized the increasing new HIV infections among young people is significant as it may have influenced the following policies on health to recognize HIV and STIs among adolescents and young people as a significant concern to be addressed. However, the policy does not specifically refer to the four components of right to health as defined in the General Comment No. 14.

The National HIV AIDS Policy 2011 aims to prevent HIV and other sexually transmitted infections in Sri Lanka by reducing new HIV infections through (1) sexual transmission, (2) mother to child transmission and (3) transmission through blood and blood products of HIV. The policy contains comprehensive approaches to addressing the rise of new HIV infections in comparison to previous policies. First and foremost, it recognizes the importance of providing special attention to "in and out of school youth" within the prevention interventions (National HIV AIDS Policy 2011, pp. 19-20) and the need to provide special attention to youth within "responsible behavior" interventions. Strategies 1, 2, 6 and 11 are specific in terms of facilitating the right of adolescents to health and access HIV testing. Strategy 1 recognizes the significance of special attention provided to "in and out of school youth" in prevention interventions Strategy 2 identifies youth is a specific population where interventions on "responsible behavior" should be implemented (National HIV AIDS Policy 2011, pp. 20-21). Strategy 6 specifically focuses on HIV testing and obliges the state to provide voluntary HIV testing and counselling according to accepted international guidelines. Strategy 11 refers to the Human Rights in addressing HIV. It obliges the state to address stigma and discrimination in order to provide an enabling environment to seek relevant services (National HIV AIDS Policy 2011, pp. 22-23). The strategy specifically identifies rights of everyone to life, liberty and security of person,

freedom from inhuman or degrading treatment or punishment, equality before law, absence of discrimination, and freedom from arbitrary interference with privacy or family life, freedom of a standard of living adequate for health and well-being including housing, food and clothing, the right to the highest attainable standard of physical and mental health, the right to education, the right to information which includes the right to knowledge about HIV/AIDS/STI related issues and safer sexual practices, the right to capacity building of the individuals in dealing with this condition, the right to participate in the cultural life of the community and to share in scientific advancement and it's benefit. More importantly this is the only policy that refers to highest attainable health and the right to information on HIV related issues (National HIV AIDS Policy 2011, p. 23). However, the policy does not recognize means through which rights of people to health in the context of HIV could be respected, protected and fulfilled. It also contains no reference to ICESCR, CRC, CEDAW or the General Comment No 14 in defining the right to access HIV health services of the Sri Lankan Citizens.

National Policy on Maternal and Child Health of 2012 envisions to realize a Sri Lankan Nation that has optimized the quality of life and health potential of all women, children and families. It aims to contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, culturally acceptable and family friendly settings (National Policy on Maternal and Child Health 2012, p. 15). Goal 1 of the policy refers to "Promotion of health of women and their partners to enter pregnancy in optimal health, and to maintain it throughout the life course" (National Policy on Maternal and Child Health 2012, p. 17). The description of the goal contains the significance of providing women of child bearing age with comprehensive HIV services. Not only does these capture children but also adolescents and young girls who are of child bearing age. However, the policy fails to recognize and acknowledge more comprehensive approaches to provide sexual and reproductive health services. It does not recognize the emerging sexualities of children, adolescents and young people in the context of sexual and reproductive health.

National Strategic Plan – Adolescent Health of 2013 envisions to "ensure that adolescents realize their full potential for growth and development in a conducive and resourceful physical and psychosocial environment". It aims to Improve adolescent health by empowering them with knowledge, attitudes, skills and opportunities for optimum

development and by providing a safe, supportive and promotive environment in home, school and neighborhood which facilitate healthy transition into adulthood (National Strategic Plan – Adolescent Health 2013, p. 18). The policy in its background refer to both CRC and CEDAW and acknowledges the right to health elements in both these conventions (National Strategic Plan – Adolescent Health 2013, p. 13). More importantly, it also recognizes the need for restructuring the health systems to recognize the unique needs of adolescents (National Strategic Plan – Adolescent Health 2013, p. 9). Goal 4 of the policy refer to "reduce STD/HIV among adolescents". The very fact that this is included as a specific goal signifies the recognition of addressing HIV among adolescents as a major concern. Strategic objective 5 and 6 of the policy recognizes the importance of improving quality and coverage of sexual and reproductive health education for adolescents and increasing accessibility to contraceptives/ family planning services for sexually active adolescents (National Strategic Plan – Adolescent Health 2013, pp. 18-19). The policy under key area 2, Human Resource Development, identifies the importance of building the capacity of health service providers in improving adolescent health (National Strategic Plan – Adolescent Health 2013, p. 21). Under key area 3, Health Service Delivery, the policy recognizes the need to deliver evidence based interventions on adolescent health and identifies the need to develop minimum health packages, standard operating procedures and developing guidelines and protocols (National Strategic Plan – Adolescent Health 2013, pp. 22-24). The policy also refers to adolescent friendly health services and identifies the significance of ensuring availability and accessibility of services delivered in adolescent friendly manner (National Strategic Plan – Adolescent Health 2013, p. 22). This strategic plan could be identified as one of the most comprehensive among all the policies studied. It specifically identifies that adolescents are sexually active and therefore require sexual and reproductive health services. It also recognizes that service providers require training and capacity building in order to provide friendly health services to adolescents. The strategy also recognizes the importance of availability and accessibility of health services which are two components of right to health as defined in General Comment No. 14 of the CESCR.

National Youth Policy of 2014 envisions to "develop the full potential of young people to enable their active participation in national development for a just and equitable society" (National Youth Policy 2014, p. 7) and is based on a three pillar approach which is consisted of Ensuring youth, making sure that there is a conducive, supportive and equitable

environment and opportunities for youth to flourish; enabling youth, creating conditions where youth can be independent, creative, innovative and confident and Empowering youth, strengthening youth to participate and take responsibility on behalf of themselves, their community and humanity (National Youth Policy 2014, p. 5). The values and principles that underline the National Youth Policy refers to "Promoting total wellbeing of youth including physical, mental, spiritual, material and cultural" (National Youth Policy 2014, p. 5). The national Youth Policy is significant for several reasons. Similar to strategic plan on adolescent health, the National Youth policy acknowledges that adolescents and young people are sexually active but the services on sexual and reproductive health specific to young people are lacking (National Youth Policy 2014, p. 12). It recognizes the need for policy interventions that facilitate quality and access to youth-friendly health services (National Youth Policy 2014, p. 8), significance of integrating comprehensive sexuality education to school curricula and building the capacity of health professional to respond to youth health issues (National Youth Policy 2014, p. 22). The health components of the National Youth Policy are an improvement from many other previous polices related to young people and sexual health. However, the policy fails to recognize the urgency of providing access to HIV health services for young people especially with the rising new HIV infections among young people in the country (NSACP 2013). It also does not recognize the rights of young people to highest attainable health.

National Policy and Strategy on Health of Young Persons of 2015 could be recognized as another significant policy that directly address the right of young people to highest attainable health. The policy envisions a "Happy, healthy and skillful Sri Lankan youth" while it aims to mainstream concerns of the health of young people and to improve their health, safety and well-being (National Policy and Strategy on Health of Young Persons 2015, p. 229). The policy recognizes that adolescent and young people in the country lack knowledge on sexual and reproductive health and concerns but at the same time "a fair proportion of in-school adolescents appear to be sexually active". In its guiding principles it recalls the obligations of the Sri Lankan state in line with the international human rights instruments to which it's a state party. In comparison to preceding policies on young people and their well-being, this policy recognizes that "young persons have a right to access quality health services, to address their specific needs and issues, and that such services are delivered in a friendly, culturally sensitive, non-threatening and non-judgmental manner,

while recognizing and respecting their sexual and reproductive rights" (National Policy and Strategy on Health of Young Persons 2015, pp. 227-228). It is, in fact the first and only policy that specifically recognizes and acknowledges the right of adolescents and young people to health and their sexual and reproductive rights. Strategy 6 and 8 of the policy specifically refers to the need for reproductive health services and the availability of accessible, acceptable and appropriate services which are youth friendly (National Policy and Strategy on Health of Young Persons 2015, pp. 227-234). In general, the national Policy on the Health of Young Persons could be identified as one of the progressive policies that encompasses the realities of young people in today's world and its effort to meet sexual and reproductive health services of young people through youth friendly sexual and reproductive health services is commendable. However, the policy does not expand on what sexual and reproductive health services entail and to which extent adolescents can independently access these services.

The circular issued by the Ministry of Health Sri Lanka in 2015 entitled "Providing Sexual and Reproductive Health Services to Adolescents" could be identified as a turning point in respecting, protecting and fulfilling adolescents' right to access sexual and reproductive health services including HIV testing. The circular recognizes the discrepancies in the legal framework of the country in providing SRH services to adolescents and mandates that the "basic concern" of "health care workers" when providing SRH services to adolescents should be the "best interest of the child" (the circular uses "adolescents" and "child" interchangeably). Adolescent sexual and reproductive health services in the circular includes pre and post pregnancy care, contraceptives and family planning services, post abortion care, care and management of STI and HIV/ AIDS and Prevention, care and management of gender based violence. It further states that the "decisions on best interest should be assessed by the Medical Officers on a case by case basis". However, the circular also mandates that

> "Considering the norms of the country, the Medical Officer must take all reasonable measures to obtain parental/guardian consent to providing such services. However, where the Medical Officer is unable to obtain parental/

guardian consent, reproductive health services should be provided even in the absence of parental consent, in the best interest of the child"

While this circular facilitates a broad opportunity for the Medical Officers to provide SRH services to adolescents and thus protect and promote the right of adolescents to access HIV testing and other SRH services, it also places a significant decision making power with the Medical Officers as it mandates the Medical Officers to assess each decision on a case by case basis. Such decision making processes could drastically facilitate adolescents independent access to HIV testing but could also significantly limit their access since the circular has appointed Medical Officers as the "gate-keepers" of adolescents' access to HIV testing and other SRH services facilitating "gate-keeping mechanisms".

Sri Lanka currently does not have a National Health Policy. A draft National Health Policy for the period of 2016 – 2025 is available and has not yet been adopted. The previous National Health Policy was adopted in 1996. The draft National Health Policy of 2016 recognizes the newly emerged and emerging health issues of the population and the need for a change in the health systems to improve quality and safety, to be able to respond to the needs and expectations of the new generation, and also to accommodate the demographic, epidemiological and socio-economic transitions (National Health Policy 2016, p. 2-3). The draft policy identifies HIV/AIDS among several other communicable diseases to require "utmost attention" and the need to establish a system to ensure the rights of patients and their access to systematically updated services (National Health Policy 2016, pp. 5-6). The policy recognizes the significance of a patient centered health system which facilitates universal health coverage including equitable access to services by all patients, equitable distribution of services to all patients, quality service to all patients and financial protection of all patients, assuring the patient's right and social justice (National Health Policy 2016, p. 9). However, as a whole, the policy does not explicitly refer to the right of Sri Lankan citizens to the highest attainable health. In its draft it does not refer to any of the international human rights instruments, especially ICESCR, CEDAW, CRC and the General Comment No 14 of the CESCR in establishing a rights framework for the national Health Policy.

The most recent policy analyzed for this study is the National HIV Strategic Plan developed by the National STD/ AIDS Control Program of Sri Lanka for the period of 2018 – 2022. The strategic plan aims to prevent new infections of HIV/STI among key populations, vulnerable populations and the general population. In its strategic direction 1.3, the strategic plan recognizes prevention of transmission of HIV/STI among general population including young people (National HIV Strategic Plan 2018, p. 9). However, it does not identify increasing HIV testing among young people as a key strategy to achieve prevention targets (Heffelfinger et al 2011). The objective 3 of the strategy refers to the provision of universal access to HIV/STI diagnosis and treatment, care and support services for those infected and affected by HIV/STI (National HIV Strategic Plan 2018, p. 7). Yet, it does not recognize the need to specifically extend universal access to HIV testing for adolescents and young people in the country. The strategy, as in many preceding policies and strategies, do not recognize the right of Sri Lankan citizens to the highest attainable health. Nor does it use any of the international human rights instruments and specific international decelerations on HIV such as the High Level Political Declaration on HIV 2016, to frame the right of citizens to highest attainable health.

III. The International Human Rights Instruments and Right to Highest Attainable Health

The article 12 of the International Convention on Economic Social and Cultural Rights (ICESCR), Article 24 of the International Convention on the Rights of the Child (CRC) and the General Comment no 14 of the Committee on the Economic, Social and Cultural Rights (CESCR) provides a convincing framework to understand the right to highest attainable health of people in general and young people in particular. The Scope of right to health could be traced with article 12 of the ICESCR and General Comment 14 of CESR. Article 12 of ICESCR establishes the right to highest attainable standard of physical and mental health and obliges the states "to take steps" for the full realization of this right. Right to health is not limited to "right to health care" but it embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment (ICESCR, art 04). Right to health also have 4 main components including

availability, accessibility, acceptability and quality in terms of available health care (CESCR, art 12). The measures taken by the states to fulfill this right also need to encompass a gender perspective (CESCR, art 20). The General Comment 14 also sets "general legal obligations" for the state. These include the immediate obligation of the state to guarantee non-discrimination (CESCR, art 30), obligations to respect, protect and fulfill (CESCR, art 33), refrain from denying or limiting equal access for all persons (CESCR, art 34) and to take other measures ensuring equal access to health care and health-related services provided by third parties (CESCR, art 35). According to article 8 of CESCR, right to health contains both freedoms and entitlements and article 36 of CESCR refer to the state obligation to give sufficient recognition to the right to health in the national policy and legal systems, preferably by way of legislative implementation. Hence, right to health is comprehensively and explicitly laid out in the ICESCR and General Comment No. 14 with clear indication at the justiciability of right to health.

Article 24 of the CRC refers to the obligation of state parties to recognize the right of the child to the enjoyment of the highest attainable standard of health. It also obliges the state parties to facilities for the treatment of illness and rehabilitation of health. It further states that states parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. Sub articles in article 24 of CRC lay out the obligations of the state to facilitate provision of necessary health care and medical assistance to all children, application of readily available technology to combat disease and malnutrition, access to information and basic knowledge on health issues and development of preventive health care, guidance for parents and family planning education and services among others. Hence, the CRC also establishes a comprehensive approach to right to health of children, adolescents and young people which is not only limited to provision of health care and medical services but also to the recognition of the very right of children to health.

IV. The National Policy Framework and the Right of Adolescents to HIV Testing

The existing policy framework in Sri Lanka in relation to adolescents, their right to highest attainable health, their access to sexual and reproductive health services including HIV testing when compared with the international standards set by the ICESCR, General Comment No 14 of the CESCR and the CRC is not very convincing. However, several key

strengths of the exiting policy framework could be identified. The availability of number of policies and strategic plans which specifically or partially address the health concerns of adolescents and young people over a period of 2 decades could be identified as a strength of the existing policy framework. The existence of the National Strategic Plan on Adolescent Health of 2013, National Policy and Strategy on Health of Young Persons of 2015 and the National Youth Policy of 2014 could also be identified as significant strengths of the current policy framework as these policies specifically refer to the need for improved sexual and reproductive health services targeted at adolescents and young people.

Several policies and strategic plans analyzed for this study refer to the rights of citizens and or adolescents'/young people's right to highest attainable health. Out of the 11 polices and strategic plans analyzed, 4 specifically refer to the right of people to highest attainable health. The National Policy on HIV and AIDS in the World of Work of 2010 specifically refer to rights of workers and their right to be free from stigma and discrimination. The National AIDS policy of 2011 refers to a range of human rights including the rights of everyone to life, liberty and security of person, freedom from inhuman or degrading treatment or punishment, equality before law, absence of discrimination, and freedom from arbitrary interference with privacy or family life, freedom of a standard of living adequate for health and well-being. The National Policy and Strategy on the Health of Young Persons of 2015 specifically refers to the obligations of the state as a signatory to many international conventions and is convinced that young persons have a right to access quality health services. The right of adolescents to access sexual and reproductive health services including HIV testing treatment, prevention and care services is recognized in the circular issued by the Ministry of Health of Sri Lanka in 2015 titled "Providing Sexual and Reproductive Health Services to Adolescents" recognizes.

Several policy documents analyzed for this study recognizes that adolescent and young people are sexually active and therefore require access to appropriate sexual and reproductive health services. According to a 2008 study in Sri Lanka, sexual debut for both males and females is found to be around 15 years. While prevalence of sexual activity among school going adolescents remained at 10.2 percent, it was at 22.2 percent among out of school adolescents (Agampodi et al. 2008, p. 2). Another study found that condom use among adolescents, a prevention mechanism for HIV, sexuality transmitted infections (STIs) and unplanned pregnancies, is relatively low in Sri Lanka (Health Policy Program

2003, p. 7). It is crucial that the existing policy framework recognizes and acknowledges this reality among adolescents and young people as such recognition can facilitate respect, protection and fulfillment of adolescents' and young people's right to access HIV testing as part of their larger right to access sexual and reproductive health services. National Youth Policy of 2014recognizes that "adolescents are also found to be having sex with commercial sex workers" and that "young people find it difficult to access information with regard to sexual and reproductive health. Youth with different sexual orientations or facing personal crises often have no support" (National Youth Policy 2014, p. 12). National Policy and Strategy on Health of Young Persons recognizes that "a fair proportion of in-school adolescents appear to be sexually active" (National Policy and Strategy on Health of Young Persons 2015, p. 227). It further distinguishes sexual interactions between in-school and out-of-school adolescents and heterosexual and homosexual sexual interactions. The National Strategic Plan on Adolescent Health of 2013 also recognizes that 6 percent of 14-19 year olds in schools and 22 percent of out of school adolescents have had sexual experiences with heterosexual partners while 10 percent in school and 9 percent out of school adolescents have had homosexual relationships (National Strategic Plan on Adolescent Health 2013, p. 11).

Several policy documents recognize the need for restructuring the health system to meet the health needs of adolescents and the need for training and capacity building for the health service providers to provide friendly health services to adolescents and young people. Many research studies attest that SRH service providers are "judgmental" of the adolescents who are accessing SRH services (Hagey et al. 2015; Lindberg et al. 2006; Newton-Levinson et al. 2016; Mbeba et al 2012). Research findings on health service providers' perception towards sexual behavior among adolescents reveals a general consensus on adolescents' immaturity to engage in sexual behavior which influences the health service providers' decision making on providing SRH services to adolescents (Chandra-Mouli et al. 2014; Geibel et al. 2016; Goicolea et al 2010; Hagey et al. 2015; Langhaug et al. 2003; Newton-Levinson et al. 2016; Mbeba et al. 2012). It is crucial that the existing policy framework recognizes the short comings in current service provision in providing friendly and accessible services to adolescents and young people and accordingly mandates restructuring existing systems to accommodate the health needs of adolescents and young people. The National Strategic Plan on Adolescent Health (NSAH 2013) recognizes the need to

restructure the existing health systems to meet the needs of adolescents and the need to build the capacity of health services providers. It also mandates developing standard guidelines to provide health services to adolescents and adapting new systems to teach sensitive subjects to services providers (The National Strategic Plan on Adolescent Health 2013, pp. 3 -21). The National Youth Policy of 2014 also recognizes the need to build capacity of health services providers to respond to youth health issues.

Similarly, several key gaps could be identified in the current policy framework. Even though some of the policy documents and strategic plans do recognize the right to highest attainable health, the existing policy framework as a whole lacks a comprehensive human rights and right to health approach. All policies analyzed for this study do not refer to the four key components of right to health as stipulated in General Comment No 14 of CESCR which include availability, accessibility, acceptability and quality despite the fact that General Comment No 14 was issued in year 2000. Almost all the policies analyzed for this study were adopted after year 2000. The polices do not refer to directive principles of the constitution of Sri Lanka, nor do they refer specifically to article 12 of the ICESCR, Article 24 of CRC or CEDW which specifically mentions right to health in International Human Rights Instruments. Hence, the policy framework clearly lacks a comprehensive and an explicit reference to the right to highest attainable health which may impact in implementing strategies that are geared towards respecting, protecting and fulfilling the right to health of adolescents and young people.

Adolescents and young people are increasingly becoming vulnerable to HIV (UNICEF 2018). A systematic review done by the UN Inter Agency Task Team on Young People has highlighted this fact in 2006 among others (UN IATT 2006). The current data of the NSACP of Sri Lanka also reveals the same. An analysis of figures of new HIV infections among young people in the annual reports of the NSACP since 2011 shows a significant percentage increase in the new HIV infections among young people. Despite this fact, the polices that specifically focus on the health issues of adolescents and young people including the National HIV AIDS Policy of 2011, National Strategic Plan on Adolescent Health of 2013, National Youth Policy of 2014, the National Policy and Strategy on the Health of Young person of 2014 and the National HIV Strategic Plan of NSACP 2018 – 2022 do not focus on the importance of increasing HIV testing among adolescents and young people as one of the effective strategies to address rising HIV incidences among

adolescents and young people. Even though the polices recognize the need for improved access to sexual and reproductive health services for adolescent, the lack of explicit references to increasing HIV testing among adolescents and young people needs to be identified as an alarming gap in the existing policy framework.

The policies do not address the legal challenges faced by adolescents in accessing available HIV services such as consent requirements in case of minors. All policies that have been adopted prior to 2015 (before the issuance of the circular by the Ministry of Health on provision of sexual and reproductive health services to adolescents) do not recognize the age of consent challenges that adolescents and service providers may face in accessing and providing sexual and reproductive health services including HIV testing to adolescents and young people. The policies do not provide clear guidance to health service providers to provide sexual and reproductive health services in the absence of parental or guardian consent. A number of policies adopted prior to 2015 recognizes that adolescents are sexually active and therefore are in need of comprehensive sexual and reproductive health services. However, the lack of explicit references to addressing consent challenges remains an alarming gap in the existing policy framework.

V. Conclusion

The existing policy framework of the country in relation to adolescents right to access HIV testing and know their status does not strongly facilitate the adolescents' right to HIV testing. However, at the same time, it is also important to recognize the importance of rights and right to health elements incorporated in several polices. Even though the polices explicitly do not refer to the need to increase HIV testing among adolescents and young people as an effective strategy to address rising HIV infections among adolescents and young people, the recognition of adolescents being sexually active and therefore the need to provide friendly health services are important aspects. Similarly, the recognition of the need to restructure the health system and build the capacity of health service providers and other staff to meet the emerging health issues of adolescents and young people and to provide youth friendly health services are also major break troughs in the exiting policy framework. However, it is important to understand that HIV is a complex phenomenon. Apart from the required medical interventions, it also requires social interventions to address stigma,

discrimination and address other psycho-social issues such as suicide, partner/ family notification, disclosure and etc. Despite the available data revealing the rising HIV epidemic among adolescents and young pole, the current policy framework does not provide substantive measure to accommodate the complex needs of adolescents in relation to their health needs in the context of HIV. The policy framework also does not provide concrete avenues for the service providers to operate in a right to health framework which will first and foremost respect, protect and fulfill the adolescents right to highest attainable health including their right to access HIV testing and know their status.

Bibliography

Agampodi, S Agampodi, T & Piyaseeli, U 2008, 'Adolescents perception of reproductive health care services in Sri Lanka', *BMC Health Services Research*, vol. 8, no. 98, pp. 1-8.

Annual Report 2013, *National STD AIDS Control Program* (online), Available at: <http://www.aidscontrol.gov.lk/images/pdfs/publications/annual_report_2013.pdf> [Accessed 10 June 2018].

Chandra-Mouli, V McCarraher, D Phillips, S Williamson, N & Hainsworth, G 2014, 'Contraception for adolescents in low and middle income countries: needs, barriers, and access', *Reproductive Health Journal*, vol. 11, no. 1, pp. 2-16.

Constitution of Sri Lanka 1978, As amended up to 15th may 2015, Parliament Secretariat (online), Available at: <http://www.parliament.lk/files/pdf/constitution.pdf> [Accessed 9 June 2018].

Geibel, S Hossain, S Pulerwitz, J Sultana, N Hossain, T Roy, S Burnett-Zieman, B Stackpool-Moore, L Friedland, B Yasmin, R Sadiq, N & Yam, E 2016, 'Stigma Reduction Training Improves Healthcare Provider Attitudes Toward, and Experiences of, Young Marginalized People in Bangladesh', *Journal of Adolescent Health*, vol. 60, pp. 35 – 44.

Gomez, M Hartnett, C & Samararatne, D 2016, Constitutionalizing Economic and Social Rights in Sri Lanka, *CPA working papers on Constitutional Reforms No 7 – September 2016* (online), Available at: <https://www.cpalanka.org/wp-content/uploads/2016/09/Working-Paper-7.pdf> [Accessed 9 June 2018].

Government of Sri Lanka, 1988, *Population and Reproductive Health Policy (PRHP 1988)*, pp. 3-11 (online), Available at: <http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/PolicyRepository.pdf> [Accessed 9 June 2018].

Government of Sri Lanka, 2010, *National Policy on HIV and AIDS in the World of Work 2010* (NPHWW 2010), (online), Available at: <http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_126258.pdf> [Accesses 09 June 2018].

Government of Sri Lanka, 2011, *National HIV/ AIDS policy (NHAP 2011)*, (online), Available at: <http://www.aidscontrol.gov.lk/index.php?lang=en> [Accessed on 9 June 2018].

Government of Sri Lanka, *National Policy on Maternal and Child Health 2012 (NPMCH 2012)*, pp 12- 13 (online), Available at: <http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/PolicyRepository.pdf> [Accesses 10 June 2018].

Government of Sri Lanka, 2013, *National Strategic Plan - adolescent health (NSAH 2013)*, (online), Available at: <http://fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&id=57:adolescent-and-youth-health&lang=en> [Accessed on 10 June 2018].

Government of Sri Lanka, 2014, *National youth policy (NYP 2014)*, (online), Available at: <http://www.youthpolicy.org/national/Sri_Lanka_2014_National_Youth_Policy.pdf > [Accessed 10 June 2018].

Government of Sri Lanka, 2015, *National Policy and Strategy on Health of Young Persons (NPSHYP 2015)*, pp. 226 – 235 (online), Available at: <http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/Policy Repository.pdf> [Accessed 10 June 2018].

Government of Sri Lanka, 2015, *Circular on Providing SRH services to adolescents (VSRH 2015)*, (online), Available at: <http://www.health.gov.lk/CMS/cmsmoh1/viewcircular.php?cno=01-25/2015&med=english> [Accessed 10 June 2018].

Government of Sri Lanka, 2015, *Draft National health policy 2016 – 2025 (NHP 2016)*, (online), Available at: <http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/policiesUpto2016/policiesForPublicOpinion/NHP2016-2025draft.pdf> [Accessed 10 June 2018].

Government of Sri Lanka, The Interim Report of the Steering Committee [21st September 2017], *The Constitutional Assembly of Sri Lanka* (online), Available at: <https://english.constitutionalassembly.lk/images/pdf/interim-report/ReportE%20CRR.pdf> [Accessed 10 June 2018].

Hagey, J Akama, E Ayieko, J Bukusi, E Cohen, C & Patel, C 2015, 'Barriers and facilitators adolescent females living with HIV face in accessing contraceptive services: a qualitative assessment of providers' perceptions in western Kenya', *Journal of International AIDS Society*, 18:20123, pp. 1-8.

Heffelfinger, J Owen, S Hendry, R & Lansky, A 2011, 'HIV Testing: The Cornerstone of HIV Prevention Efforts in the USA', *Future Virology,* Vol 6, No 11, pp. 1299 – 1317.

Interim Report, Government of Sri Lanka, *Constitutional Assemble of Sri Lanka*, 2016(online), Available at: < https://english.constitutionalassembly.lk> [Accessed 14 June 2018].

Langhaug, L Cowan, F & Nyamurera, T 2003, 'Improving young people's access to reproductive health care in rural Zimbabwe', *AIDS Care*, vol.15, no. 2, pp. 147- 157.

Lindberg, C Lewis-Spruill, C & Crownover, R 2006, 'Barriers to sexual and reproductive health care: urban male adolescents speak out', *Issues in Comprehensive Pediatric Nursing*, vol. 29, no. 2, pp. 73-87.

Mbeba, R Mkuye, M Magembe, G Yotham, W Mellah, A & Mkuwa, S 2012, 'Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study', *Pan African Medical Journal*, 13(Supp 1):13, pp. 1-6.

National STD AIDS Control Program, *National Strategic plan on HIV 2018 – 2022* (online), Available at: <http://www.aidsdatahub.org/sites/default/files/publication/Sri_Lanka_National_HIV_STI_Strategic_Plan_2018-2022_2017.pdf> [Accessed 14 June 2018].

Newton-Levinson, A Leichliter, J & Chandra-Mouli, V 2016, ‘Sexually Transmitted Infection Services for Adolescents and Youth in Low- and Middle-Income Countries: Perceived and Experienced Barriers to Accessing Care’, *Journal of Adolescent Health*, vol. 59, pp. 7 – 16.

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4 (online), Available at: <http://www.refworld.org/docid/4538838d0.html> [Accessed 14 June 2018].

UN IATT, 2006, ‘*Preventing hiv/aids in young people, a systematic review of the evidence from developing countries*’ (online), Available at: https://www.unicef.org/aids/files/PREVENTING_HIV_AIDS_IN_YOUNG_PEOPLE__A_SYSTEMATIC_REVIEW_OF_THE_EVIDENCE_FROM_DEVELOPING_COUNTRIES_WHO_2006.pdf> [Accessed 14 June 2018].

UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3 (online), Available at: <http://www.refworld.org/docid/3ae6b36c0.html> [Accessed 14 June 2018].

UNICEF 2018, ‘*Turning the tide against AIDS will require more concentrated focus on adolescents and young people*’ (online), Available at: <https://data.unicef.org/topic/hivaids/adolescents-young-people/#> [Accessed 14 June 2018].

World Health Organization, 2011, *The Right to Health in the Constitutions of Member States of the World Health Organization South-East Asia Region* (online), Available at: <http://www.who.int/hhr/news/SEA-HHR_RtH_constitutions.pdf> [Accessed 14 June 2018].