

An Exploration of Inclusion Gaps:

An Assessment of the Health Sector

The Centre for Poverty Analysis

September 2023



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Executive Summary

This report focuses on the availability of healthcare services for the Upcountry Tamil community and the LGBTQIA+ community of the country, accessibility to such services, and the quality of their service provision. This is the second phase of a research project looking into the equitable nature of available policies and budgetary allocations in the health and transport sectors. In accordance with the findings of the first phase, this second phase of the research has narrowed its focus to the two communities mentioned above. Individuals living in and around the estate sector are referred to as Upcountry Tamil communities (Malaiyaha Tamil) in keeping with their self-identification, instead of referring to them as Indian Tamil or Estate Tamil. The areas where these communities reside and work are referred to as the estate sector, (tea) estates, or estate areas in this report.

In terms of healthcare services available to and accessible for the Upcountry Tamil community, the findings revealed that service provision by the estates themselves have worsened in quality over the years. The estate dispensaries in all the visited estates were in a dilapidated state with some wards closed down or with little to no medicine available at them. With Estate Medical Assistants (EMAs) who are not available at most times for service, or only available at their own private practices, many have opted to seek healthcare services at state-run hospitals. Although state-run hospitals are located in nearby towns, not all services can be found at a single hospital which forces individuals to visit multiple hospitals for different needs. It was also found that divisional hospital staff and midwives in most areas are putting in the effort to conduct all the main clinics (non-communicable diseases, maternity, paediatric, dental, etc.) regularly with some of them even being conducted at the estates.

One of the biggest obstacles this community faces in accessing healthcare services is the poor transport service in the area. The two services are interlinked, and poor transport service provision

affects both service providers and the patient population. The former is forced to arrange their schedules around the availability of transport services while the latter have to spend much of their earnings (at least one third of their monthly income) on using private transport to reach a hospital. Furthermore, the study also found that not all communities consulted had access to reliable ambulance services and even for such services they would have to rely on private transport. This coupled with laboratory and scan services as well as the purchasing of medicine from private pharmacies incurs a massive cost on the Upcountry Tamil community when accessing healthcare services. It was also found that there is malnutrition within the community, especially amongst the children which was mainly seen as a result of the inability to purchase nutritious food due to the low wages paid to these individuals (by the estates, farms nearby, and other day wage labour). Malnutrition also leads to children staying at home during menstruation as it would lead to severe headaches, discomfort, and even at times fainting. Another reason as to why these children would stay at home during menstruation is the lack of sanitation facilities available at schools. Period poverty is also felt by this community as it was revealed that many are unable to purchase enough sanitary napkins in order to change/wear at recommended intervals in a hygienic manner. Poor access to drinking water too was a finding in this study as it was revealed that many households still rely on the estate to provide drinking water, which at most times is twice a day. This is also coupled with the poor sanitation facilities available to these individuals. The final two issues are directly linked to the absence of land ownership rights where one cannot build toilets for themselves as multiple families would live together in one line room.

In terms of the LGBTQIA+ community, the study found that the convoluted legal framework which has made provisions for the community has not resulted in meaningful change. One of

the biggest issues the community faces is the poor operational status of trans health clinics. Whilst the state has made provisions for medical transitioning and the legal recognition of such procedures by providing a Gender Recognition Certificate, the consulted members revealed that the trans clinics do not currently provide relevant surgeries. A trans person who would want to medically transition would then have to either seek services abroad or pay up to two million Sri Lankan rupees to get the surgery done at a private hospital. Another problem faced by the trans community is the exorbitant prices of hormones; which have increased significantly since the COVID-19 pandemic and the subsequent politico-economic crisis. The study also found that trans healthcare is still bound by mental healthcare, which has a history of pathologising queerness. Trans individuals are still required by law to undergo a mental health test and validation before one is allowed to medically transition, and this topic is viewed with ambiguity by the community. It was also revealed that healthcare professionals who provide trans healthcare impose a heteronormative conception of gender on their patients, largely due to unawareness and lack of education on the matter. Discrimination towards other sexual orientation and gender identities/expressions mainly come about when persons are visibly queer – the perceived differences (especially in physical appearance and mannerisms) when combined with lack of awareness and dis- and misinformation, would lead to a denial of service or blatant discrimination by healthcare professionals. Whilst trans folk are more vulnerable to discriminatory practices within the health sector – given that their identities are made more tangible, and therefore visible, through legal processes and documents –, experiences of discrimination of persons with other sexual gender identities/expressions are generally a result of this visible queerness. When subjected to such discrimination, even these persons' access to healthcare would be limited in many ways, and this can especially be seen in access to sexual

and reproductive health.

Whilst the Global Fund¹ is providing free medicine for HIV/AIDS, it was found that the government is currently running low on necessary medicine for STIs/STDs, and this has made patients turn to private healthcare, which many cannot afford. Sex workers, especially those who are trans, were also found to have inequitable access to healthcare services. This has to do with the legality of the work they are engaged in. Sex workers' lack of awareness on safe sex and STDs/STIs make them more vulnerable to such diseases and infections. The constant arresting of sex workers, and the consequent unsafety at prisons (trans persons in cis prison wards), largely sexual assault and rape, would further exacerbate their susceptibility to contract an STD or STI. The study further found that many healthcare providers still discriminate against the LGBTQIA+ community when accessing healthcare services. The community members revealed that this is largely due to mis- and disinformation prevalent within the health sector. Added to this is the lack of LGBTQIA+ friendly or inclusive education provided to healthcare professionals in training. Out-of-pocket expenses on the LGBTQIA+ community was found to be a massive burden as it was revealed that many such individuals live away from their homes or hometowns. Whilst they live in cities and towns, due to discrimination, many are still not able to find regular employment with decent working conditions, in order to be afford private healthcare.

¹The Global Fund to Fight AIDS, Tuberculosis, and Malaria is an international financing organisation dedicated towards investing in minimising and eradicating such epidemics.

Introduction

The Sri Lankan healthcare system comprises both allopathic and indigenous modes of service provision, and such services are provided through both public and private sectors alike. The healthcare system provides preventative as well as curative services, and the services provided through public sector (i.e., state-run hospitals) are heavily subsidised. This has led to the Sri Lankan healthcare system being referred to as having universal healthcare (UHC); and yet, many of the surgeries, procedures, equipment, and even some medicines are not offered for free. The first phase of this study revealed how inequitable the majority of policies within the health sector are when it comes to service provision. The findings from that study revealed that men, the estate sector, and the LGBTQIA+ community were slipping through the cracks of healthcare provision. Whilst men's healthcare seeking behaviour was low in comparison to women (data was only available for these two genders), the estate sector did not have sufficient budgetary allocations nor services, and the LGBTQIA+ community was more or less neglected although provisions had been made. Healthcare services available at the estate sector were deemed to be below average, and there were many practical concerns related to healthcare such as the inability to provide services from the patient's own language, or the difficulties in accessing healthcare facilities due to mobility or transport issues. In terms of the LGBTQIA+ community's access to healthcare, the findings revealed that although the legal framework was making adjustments to make provisions available, LGBTQIA+ persons continued to face discrimination and receive poor services, largely due to the actions of the governing apparatus.

In light of this, this second phase of the study attempts to take a closer look at healthcare services accessed by the LGBTQIA+ community and the Upcountry Tamil community of Sri Lanka. Whilst the first phase of the study examined data collected from industry experts, academics, and policymakers, this current phase of the study has

shifted its focus to the actual members of these two communities in examining how services are accessed and obstacles faced when accessing them.

In conducting the study, the research team came across respondents from the LGBTQIA+ community using many forms of self-identification; there were respondents who identified as MSM (men who have sex with men), trans woman or trans MTF (male to female), and queer, and those who identified as queer found issue with using the term as an umbrella term to refer to the LGBTQIA+ community. Acknowledging and respecting the many different forms of self-identification, and also acknowledging the development sector's shift towards using terms such as SOGIESEC (sexual orientation, gender identity, gender expression and sex characteristics), this report uses the term LGBTQIA+² when referring to the community. However, where necessary, the terms queer or queerness are used as adjectives and nouns throughout this report. Individuals living in and around the estate sector are referred to as Upcountry Tamil communities (Malaiyaha Tamil) in keeping with their self-identification, instead of referring to them as Indian Tamil or Estate Tamil. The areas where these communities reside and work are referred to as the estate sector, (tea) estates, or estate areas in this report.

² This term is used to refer to individuals who identify themselves as lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual. However, the '+' of this term signifies that different gender and sexual expressions/identities are not limited to the terms mentioned here. For the ease of use of the acronym, the '+' is used to signify the existence of other such individuals in society.

Methodology

Research questions:

1. What sort of healthcare services are available for the LGBTQIA+ community of Sri Lanka and how does the legislature aid or hinder the provision of such services?
2. What healthcare services are available for the Upcountry Tamil community of Sri Lanka and how accessible are they?
3. What are the bottlenecks that are encountered for Public Private Partnerships (PPP)s?

Data Collection:

The data was collected through semi-structured interviews and conversations, and they were anonymised when stored. The data was collected through Focus Group Discussions (FGDs) and Key Person Interviews (KPIs) and the data was completely qualitative in nature. Nine FGDs were conducted as community consultations in four tea estates. These estates were namely Battalagalla estate in Hatton, Gordon estate in Nuwara Eliya, Spring Valley in Badulla, and Uduwara estate in Hali Ela (Badulla). In addition to this, further consultations were conducted with government officials and representatives, healthcare providers in Kandy, and development organisations. One FGD and one in-depth interview were conducted as part of data collection with the LGBTQIA+ community. These respondents represented organisations called Trans Equity of Sri Lanka (TESL) and Heart-to-Heart (H2H). For a full list of respondent details see Appendix A.

Data Analysis:

The collected data was analysed using a thematic analysis approach and was later read against the provision of equitable services. In doing so, the research team resorted to an intersectionality-based policy analysis framework (IBPA). The purpose of this framework is to analyse (public) policies going beyond their effects on singular identities of targeted groups. This framework's inception lies in healthcare and health related policies, and it is gradually now used in studying

many other sectors in relation to public policies. One of the key arguments of intersectional thinking is that human experience cannot be reduced to its single characteristics and that human experience is relative. Intersectionality, on which the IBPA framework is based, is a concept and approach forwarded by Indigenous feminist, Global South feminist, Black feminist, queer, and postcolonial thinking in response to failure to account for the lived realities of different communities and how their different identity markers shape their community or individual experiences (Hankivsky 2012).

Limitations:

Accessing respondents to get insights for the LGBTQIA+ health component was difficult. The number of respondents was low due to the difficulties in reaching out to individuals and organisations working at the grassroots level; many of these individuals rely on networks they had built over the years, and sudden requests for interviews by think tanks or development organisations are viewed with suspicion. It also seemed that some such organisations/individuals were apprehensive about being contacted for research studies of this nature given safety concerns involved. While most of the sentiments reflected on LGBTQIA+ healthcare in this paper come from these individuals' personal experiences, they were also able to share the general status of healthcare services available for the community due to their experiences in working with them closely. However, the inability to gauge ethnic, geographic/place-specific, and socio-economic nuances within the community and in relation to their access to healthcare services is acknowledged by the research team.

Findings

Health services for the Upcountry Tamil Community

Availability of services

The majority of estates to this day includes an estate dispensary. According to one key informant working with the community, prior to 1992, the management of these estate dispensaries (referred to as apothecaries) were under the estate management; however, the management of some of these dispensaries and the appointment of Estate Medical Assistants (EMAs) now comes under the government (KII, 2023).

According to the consultations with provincial government officers on health, it was revealed that close to 450 estate dispensaries exist and that approximately, 63 dispensaries were taken over by the government (FGD, Kandy, 2023). All the tea estates visited during the field visit had a designated estate dispensary. However, all of the dispensaries were found to be dysfunctional and dilapidated – most of these dispensaries had rooms and/or wards which were being used as storage space. According to the respondents, the EMAs at the dispensaries were only able to treat illnesses such as fever and treat cuts and bruises by giving out painkillers and antiseptics. Those who are appointed as EMAs at estate dispensaries are oftentimes not MBBS qualified doctors or persons with proper medical training. In some instances, these EMAs are in charge of multiple estates or divisions of estates, rendering it difficult for them to provide services at one estate dispensary for the entire day, and even when they are assigned only one estate dispensary to work at, the EMAs can only be found at the dispensaries for about two hours or half a day; “This dispensary covers three divisions. We have an EMA here and he is responsible for all three divisions. He has to cover all three divisions in a day. He is not available all day for us to meet. He comes to our dispensary only after 3:30pm in the evening”

(FGD, Battalagalla, 2023).

“We have a dispensary in our estate, but it does not function regularly. The EMA visits our dispensary on the last Thursday of the month” (FGD, Uduwara, 2023)

This absence of or the difficulty in consulting EMAs has even resulted in deaths of urgent patients and at times would incur costs on patients in looking for vehicles to go to a different hospital; “Ten years ago, a 48-year-old man suddenly got sick and fell down. We took him to this dispensary, but the EMA was not there. Then we took him to Fordyce [a different division/estate], he was not there either. Finally, we took him to the Dickoya hospital, but that man had already died on the way to the hospital. Two or three more people have died the same way” (FGD, Battalagalla, 2023).

A common finding from the majority of community consultations was how EMAs would spend a short period of time at the estate dispensary and open their private clinic at home after 5PM. These clinics provide services for a price, and it usually varies between LKR400.00 to LKR1,500.00. In terms of emergency care, persons would just go to the nearest divisional hospital for treatment, and the most frequently used mode of transport for this is the three-wheeler. As Suva Seriya ambulances are stationed at police stations, this service was not identified as the most efficient or reliable in case of an emergency;

“We have ambulance services here. If we contact them, it takes them nearly 35 minutes to reach here. The ambulance comes to the main road, and we have to take the patients down to the main road. Usually, the three-wheeler driver charges 350 rupees to reach the main road from our estate. Sometimes, if we can't find a three-wheeler, then we carry patients down to the main road in case of an emergency” (FGD, Uduwara, 2023).

“We don't have ambulance services here. So, we have to take three-wheelers instead. Then we directly go to the Nuwara Eliya hospital” (FGD, Gordon Estate, 2023).

"If we dial 1990, ambulances take nearly one hour to come here, but there are plenty of three-wheelers around here (FGD, Battalagalla, 2023)

Many respondents also claimed that many years ago (as far back as the year 1996), estates used to have their own ambulance services or trucks for emergency use, which are not provided by the estates at the moment.

Availability of clinics and state health services

Since the estate dispensaries are largely vacant and not in operation, many of the clinics conducted by the Medical Officers of Health (MoH) take place inside the dispensary building. Weighing of children, and maternity clinics are mostly held at the estate dispensary. The main mental health clinic is in Katugastota, and whenever that is too far for one to reach, hospitals in Nuwara Eliya, Badulla, and Dickoya are recommended to patients depending on the proximity.

Hatton (Battalgalla):

According to respondents from Hatton, maternity clinics are conducted at the Dickoya hospital, as the midwives gather there. Maternity clinics, dental clinics, eye clinics, and non-communicable diseases (NCDs) clinics all take place at the Dickoya hospital. Many of the young mothers who were interviewed, however, claimed that the Dickoya maternity clinic would be too time-consuming and would affect their productivity, and eventually, their income. In circumventing this, some have opted to attend maternity clinics at private hospitals where a person would spend up to LKR15,000.00 monthly on medicines, tests, and transport related costs on health.

The elderly respondents also claimed that they spend LKR1,600.00 on both public and private transport in attending NCD and other clinics monthly, with the total coming to LKR3,000.00 for both transport and medicine related costs. While many others can afford to bear such

costs, these elderly individuals of the Upcountry Tamil community are retired estate workers and they oftentimes have to borrow money from their children or find employment to cover their expenses – even this, however, is not nearly enough as they just earn about LKR700.00 a week.

Nuwara Eliya (Gordon Estate):

Maternity clinics for Nuwara Eliya respondents take place at the Nuwara Eliya hospital and at their own estate dispensary, and to attend the clinic at the hospital, they spend around LKR4,000.00 to LKR5,000.00 per month, as they often have to rely on three-wheelers. This was claimed to have been half of their monthly income. Weighing of children under five years of age takes place at the crèche, whilst other clinics such as the NCD clinic, eye clinic, and dental clinics are all available at the divisional hospital in Delmar and the Nuwara Eliya Hospital. The elderly respondents from this estate claimed that they spend around LKR800.00 on transport to reach the Delmar hospital and LKR2,000.00 to LKR3,000.00 per month on medicine.

Badulla (Spring Valley):

Spring Valley residents cannot access their estate dispensary as it no longer provides services. Maternity, paediatric, and dental clinics are available at the nearest divisional hospital, and in order to attend eye clinics and NCD clinics, patients have to reach the Badulla hospital. The respondents claimed that Suva Seriya is stationed too far to reach on time during an emergency, and so they would use private transport to reach the divisional hospital and get an ambulance from there to the Badulla hospital. It was reported that around LKR2,000.00 is charged by three-wheeler drivers to reach the Badulla hospital.

Badulla (Uduwara):

The respondents claimed that they do not have a maternity clinic at the estate and that they would go to the 6th Division to attend the clinic held there. A mental health clinic is available at the

Badulla hospital, and one NCD clinic had been conducted six months prior to data collection and not once afterwards. It was also revealed that the bus fare to Badulla was LKR100.00 and that a three-wheeler would charge around LKR1,900.00 to reach the hospital.

In addition, community members from all four estates revealed that whilst the divisional and main hospitals (state run) that they go to have some medicines, they would still have to purchase most of it from private pharmacies, and state-run pharmacies are only available at some main hospitals to which these individuals seldom have access to. It was also revealed during both community consultations and expert interviews that clinics at government hospitals operate only on weekdays in the mornings during working hours – this especially affects individuals who are employed at a tea estate, a vegetable farm, or some other form of daily wage employment, for they would have to apply for leave leading to a missed income for that day.

Sexually transmitted diseases and infections (STDs/STIs)

It was reported that STD/STI clinics were conducted for pregnant mothers by the midwives as protocol (screening during pregnancy). If and when a pregnant mother is diagnosed with an STD/STI, they are given proper treatment and their spouses too are screened for the possibility of having an STD/STI (FGD, Panvila, 2023). However, there are no STD/STI clinics or screening available for the general patient population (FGD, Kandy, 2023; FGD, Panvila, 2023), especially for men, who have more of a chance of going unreported and undiagnosed. The midwives interviewed revealed that although it is not within their role, they have initiated sessions referred to as a 'Nava Yovun Kavaya' with youths in some estates where the midwives would speak to them about STDs/STIs, pregnancy, and the importance of contraception. The midwives being younger in age compared to the parents of these youths was claimed to have been an

advantage when approaching the youth about such topics and having open conversations on them (FGD, Panvila, 2023).

Ambulances and/or emergency service vehicles

As mentioned, a few instances earlier, ambulance services or vehicles for emergency use are not reliable. This is mainly due to the visited estates being located far away from their respective police divisions/stations – whereas usually, Suva Seriya ambulances are stationed at police stations. In addition to the distance, the poor infrastructure, especially within the estates, leads to inefficiencies and delays in ambulances accessing the communities. While the shortest time for an ambulance to reach an estate was reported as 35 minutes, the longest was reported as taking close to or more than one hour. This state of ambulance services incurs an additional cost on those living in these areas as they would rather rely on an efficient service at the cost of expenses; "We dial 1990 in case of emergency. The ambulance will arrive within 1 hour. Estate does not provide any ambulance or vehicle facilities to go to the hospital. Estate provided a lorry to carry patients before but not now" (FGD, Gordon Estate, 2023).

Discriminatory Practices

Respondents also mentioned the language barrier they must get over when accessing health services. Whilst some of the Sinhala speaking healthcare providers do have some level of Tamil proficiency, instances of needing other patients who are more proficient in Sinhala being needed for translation and interpretation services were reported. This lack of fluency or proficiency in the Tamil language leads to difficulties when seeking treatment;

"There is a scarcity of doctors at this hospital. Not all doctors speak Tamil. Language barrier is a huge issue here. If the doctor does not know Tamil, he will get assistance from others to translate to Sinhala. Not everyone can translate the exact words spoken by patients. Sometimes,

it leads to misunderstandings. Sometimes, the doctor gives wrong medicines to the patients because he understood Tamil wrongly” (FGD, Gordon Estate, 2023).

However, it should also be mentioned that this issue of the language barrier was not experienced by all members, or at least not to the same extent. While as the above quote explains that this language barrier has led to miscommunication during service provision, the community members also revealed that many healthcare professionals working in the area (whose primary language would be Sinhala) are putting in the effort to learn Tamil and request for help with translations and interpretations when needed.

Another important finding, although not mentioned by most, was the blatant discrimination patients experienced by the hands of healthcare providers owing to their identity. It was implied by the respondents that this physical form of discrimination or treatment was due to their identity of being Upcountry Tamil, or for working at tea estates, or for being daily wage workers;

“In the divisional hospital the doctors and the staff still treat us like corona patients. The doctor sits two metres away from us and asks about our sickness. They still maintain social distance from the patients. The doctor gives antibiotics to all who come to see the doctor. Sometimes he gives antibiotics even before we are seated in a chair. If we go to the doctor for a cold, he will give tablets for headaches and fever in advance. This doctor does not touch to treat us. He does not even use a stethoscope” (FGD, Spring Valley, 2023).

³ A cereal made of grains and provided for free by the government to all pregnant mothers, mothers who breastfeed (with an infant up to the age of 06 months), and infants over 06 months of age and children below 05 years of age.

⁴ An implementing agency under the administration of the State Ministry of Estate Housing and Community Infrastructure.

Nutrition

Another great difficulty faced by the communities interviewed and consulted was malnutrition or the difficulty in accessing nutritious food. This was mainly seen in relation to the haphazard distribution of thripasha³ to toddlers. Young mothers from the Gordon estate claimed that they were only given thripasha in August of 2023 after a long period of zero distribution. Mothers from Battalgalla said that only children under the age of three and pregnant mothers receive thripasha, and lastly, mothers from Uduwara claimed that only children who are considered to be underweight receive thripasha.

One of the main reasons for malnutrition in the area is their inability to purchase nutritious food and this was reflected in their consumption of eggs which many revealed that they (mostly their children) would have one egg per month or every few months. The most easily available nutritious food for the some of those interviewed was spinach and even this was only available during the rainy season. Many claimed that their income was only sufficient to purchase rice and flour.

Period poverty

Consultations conducted with community members, state health officials, and Prajashakthi⁴ revealed that period poverty is also faced by residents of these estates. Although sanitary napkins are taxed exorbitantly, rendering them very expensive, parents of children of these estates do whatever is in their power to purchase sanitary napkins for their children;

33 **Our parents somehow find the money to buy napkins. We use cloth napkins instead of pads at home, because the price of sanitary pads is really high these days”**
(FGD, Uduwara, 2023)

This would mean that parents would be indebted at times when purchasing sanitary napkins as they do not make enough of a daily or monthly income to purchase them. Women and girls also have resorted to rationing their sanitary napkins, only wearing them when going outside for work or school and wearing makeshift cloth napkins at home. This has led to many health complications in terms of hygiene, for they do not change sanitary napkins as frequently as one is supposed to and oftentimes, the cloth napkins made at home are not sterilised resulting in a conducive environment for infections. Some of the respondents, however, did mention a few non-governmental organisations (NGOs) conducting awareness raising sessions on making clean cloth napkins at home and related basic hygienic practices (FGD, Gordon Estate, 2023). Whilst no school dropouts were reported during community consultations due to menstruation, according to the respondents, other related issues on the availability of sanitary facilities were reported to have discouraged students from attending school. As one is supposed to change their sanitary napkins every three to four hours or so, students would have to use toilet facilities available at school. However, since there are not enough water facilities available at school, children would stay at home on their period to avoid uncomfortable situations and/or infections;

33 The school only gets water two or three days a week, and if we are on our period on a day when there's no water at school, then we can't go. Our teachers have told us that we need to change our sanitary napkins often and we need to clean properly when we go use the washroom when menstruating, but we can't do this at school when there's no water" (FGD, Uduwara, 2023).

Another factor which contributes to children staying at home when menstruating is malnutrition. Some respondents claimed their children would faint when they are on their period as they do not get enough nutrition to go about their day and be productive. To avoid fainting at school or on the way to school or back home, children would then stay at home until they feel better.

Access to drinking water

Access to drinking water was also cited as one of the main problems faced by these communities. According to the respondents, in order to install a direct pipeline, it would now cost about LKR90,000.00 to LKR100,000.00⁵, which is not an amount many can afford to bear. In the absence of direct pipelines, these individuals rely on old water tanks (overhead) built by the estate management for their daily use. These tanks are usually filled by water springs and streams found on hills and they would run dry in the dry season, making accessing drinking water even more difficult. It was reported that organisations such as the Institute for Social Development⁶ have contributed to the communities by way of constructing overhead water tanks, especially in the Gordon estate. This lack of access to drinking water (or clean water in general) affects the adults' productivity and their daily income too, as they would need to fetch water for their children;

"Nurseries have toilet facilities but no water facilities. All parents have to pour 2 buckets of water to the nursery tank every day. Nursery has no water supply as there are only a few students studying there" (FGD, Gordon Estate, 2023).

Parents at the Gordon Estate have enrolled their students at the nursery due to the Child

⁵ Approximately USD279.00 to USD310.00

⁶ A Kandy-based non-governmental organisation working on human rights, labour, and gender advocacy. More information can be found at: <https://www.isdkandy.org/>

Development Centre (CDC) in the estate not having any toilet facilities. This costs them LKR1,000.00 per month. The lack of toilet facilities is not limited to CDCs as it is rampant throughout the entire estate sector of the country. Respondents from the Battalagalla estate revealed that one line room/house shares one toilet between up to 12 individuals, and those who do not have access to toilet facilities would either go to a neighbour's or a relative's. Respondents from Badulla and Nuwara Eliya claimed that since the toilets built by estate management were too damaged to be used by anyone, they themselves had replaced them with their own money. However, many other did not have the same opportunities;

"some people faced problems while constructing their houses as those lands belonged to the estate. The estate management did not allow some people to construct houses on their own" (FGD, Uduwara, 2023).

Discussion

The above findings in relation to the Upcountry Tamil community evidences the absence or lack of equitable health services provided for them. One of the most apparent difficulties this community continues to face is the mismatch between their daily wages and expenses borne by them in accessing services, and these expenses are borne by them due to poor service provision by the state and negligence by the estate management. Whilst the maximum a worker at a tea estate can earn is LKR1,000.00, the expenses reported go well beyond the income earned. In a situation where the estate management refuses to increase the worker population's wages, it then becomes the state's responsibility to put in measures to provide services that would reduce costs borne by the public. The absence of a functional EMA, estate dispensary, or even an MBBS qualified doctor at an estate point to the lack of care shown by the estate management and the state for the wellbeing of the individuals working and living at tea estates. Going further, allowing EMAs to

have private clinics, especially when they lack proper medical training, indicates the extent to which the workers' health means to authorities. On top of having to pay for their healthcare needs, this absence of proper care compels individuals to reach divisional, main, and even private hospitals. Cost deductions in accessing these services are also impossible given that public transport (including private buses) and emergency services such as ambulances, are not readily available, forcing people to rely on private transport. Since private transport services are also unregulated, transport costs to access other services are exorbitant. Furthermore, the majority of out-of-pocket expenses borne by these individuals are the result of the state and the estate management's failure to understand the working conditions of the community and the extent to which services should be provided. For instance, although the state-run hospitals from which these individuals seek treatment do have some medicines, in order to get other medicines needed, going to private pharmacies is needed. Another example of such ignorance or unawareness is conducting clinics at government hospitals on weekdays during working hours. This would mean that in order to receive healthcare services, one would have to apply for leave from work and lose their wages for that day. Stocking the estate dispensaries with medicine and subsidising them and conducting clinics on weekends and making some of them mobile would help bring down the expenses borne by these individuals; and yet, the management structures involved in making such decisions have not taken necessary steps in this direction. Equitable service provision cannot be provided by the healthcare sector alone, especially when the management structures possess the ability create a conducive environment for a better service provision.

The continued existence of neo-colonial practices of bonded and forced labour (Alawattage and Wickramasinghe, 2008; Dishanka and Ikemoto,

2014; Neubert, 2015) can be identified as the root cause of many of these problems examined in this case study. The absence of land ownership and rights continues to affect these communities in the form of poor sanitation facilities and access to drinking water, which in modern day should be readily available as basic necessities. Even though many individuals seem to be moving away from tea estates as a destination of employment, the inability to earn a sufficient income to permanently move out of the estate leaves them in a precarious state wherein some of the services provided by the estate management and Plantation Human Development Trust (PHDT), such as the estate dispensary and the CDC, are not open to these individuals. The most vulnerable group in this scenario is the retired estate workers, for whom the estate is no longer responsible. In order to cover their own medical expenses, some have found work at different estates or borrowed money from their own children. The former is worse with exploitative labour practices with an elderly worker only getting paid between LKR500.00 to LKR700.00 a week, which is barely enough to even get to the nearest government hospital. A vast majority of these workers, according to the respondents, are not recipients of any of the social welfare schemes available (Samurdhi, Aswesuma, senior citizen allowance, etc.). The treatment of individuals seems to render them stateless citizens in a liminality wherein neither the estate management nor the state seems to care for their wellbeing.

This is partly due to the lack of accountable governance and political will, especially in the area. Many respondents revealed the poor service they receive from the local Grama Niladhari (GN) and the discriminatory practices still in existence within the local governance and administrative structure(s). Community consultations in the Gordon Estate, especially evidenced this:

“We can meet the GN only on Wednesdays and Fridays. We can’t meet him even during his office hours. We have to travel by bus for 20 minutes

for this. We don’t receive any allowances from the government. He doesn’t announce anything publicly to us. He does favours only in his close circle. He provides assistance only to about 20 people and not more than that. He’s Sinhalese and he doesn’t understand us. If we go there to meet him in the afternoon, he asks us to come back the next day. Last year, my uncle went to see him to get his signature for his son’s scholarship. He didn’t place his signature on the form as my uncle went 15 minutes later to his office. As a result of this, his son lost his scholarship”

“My mother is disabled. I went to meet the GN to receive my mother’s allowance for persons with disabilities, but he refused to provide that payment” (FGD, Gordon Estate, 2023)

The same respondents also revealed how this same administrative structure poorly implemented the Aswesuma scheme by sending a preferential list of beneficiaries to the Divisional Secretariat leaving out those who actually needed the welfare. Similar sentiments were shared by the elderly respondents in Spring Valley, who claimed that the GN was biased towards his own ethnic community (Sinhala) when selecting beneficiaries for social welfare;

“We face difficulties in communicating with him. He does not inform us of anything related to government support... None of us gets the senior citizen allowance. When we went to the GN to talk about these allowances, he said that there is no law to provide it to us. Only the Sinhala are getting help from the government. We haven’t received any support from the government”

(FGD, Spring Valley, 2023).

This lack of accountability and transparency in providing welfare can also be seen in aid being directed towards the Upcountry Tamil community. An example of this is the houses built for the community by PHDT. Although the PHDT managed to build some houses for those dwelling in line rooms, the provision of these houses was claimed to be biased by the respondents; most

of these houses were claimed to have been given to those with union member or party member affiliations. The findings from the community consultations revealed that since these houses were built where the old tea plants are located, some members were reluctant to go and settle in these houses as they were difficult to reach. Aside from this practical issue, another issue raised by the respondents was the difficulty of moving into a better household when the other families in

your line room do not have the same opportunity to do so (FGD, Battalagalla, 2023). This lack of understanding of cultural nuances seems to be present in many of the measure taken by the government in addressing this community's issues. This can be especially seen in relation to the state's and the estate management's inability to understand the community's relationship with the land they have been living on for centuries now.

Health services available for the LGBTQIA+ community

Health services which are accessed by the LGBTQIA+ community apart from general healthcare include STD/STI clinics which also include care for HIV/AIDS, trans healthcare, and mental health. This, however, does not mean that one's sexual orientation and gender identity/ expression does not affect their access to general healthcare, and this is especially the case if you are "visibly queer"⁷. According to the latest available data, 40 STD/STI clinics are available throughout the island with some districts just having one clinic, and in addition to this, 29 more branch clinics are also available (National STD/ AIDS Control Programme, 2022). Whilst HIV/ AIDS is screened for at STD clinics, antiretroviral treatment (ART) (treatment for persons infected with HIV/AIDS) is only available in at the National STD/AIDS Control Programme in Colombo, Teaching Hospital in Kalubovila, Teaching Hospital in Ragama, and the STD clinic in Kandy. Although the respondents were not aware of mental health care providers specifically specialised in LGBTQIA+ persons, the availability of counsellors at the STD/STI clinics was mentioned; "At the STD clinic, we have a doctor. The doctor is a consultant, and they are not specifically assigned to be a counsellor. While the doctor is attending to other matters like checking patients, they also offer counselling services and their table has a 'counsellor' nameplate" (FGD, H2H, 2023).

Sri Lanka, at the moment, has five dedicated clinics for trans healthcare. These clinics can be found at the Kandy National Hospital, Jaffna

Teaching Hospital, Karapitiya Teaching Hospital, Kalubowila Teaching Hospital, Ragama (Colombo North) Teaching Hospital, and Mulleriyawa (Colombo East) Base Hospital where the main trans clinic referred to as Navodya clinic can be found. It was reported in the first phase of this study that procedures for medical transition (top and bottom surgery) were provided at some of these clinics to transition; however, this current phase of data collection revealed that medical surgeries for trans persons were only carried out in government hospital in the country once as a test. According to our respondents, even this pilot surgery had led to complications for the patient and has affected their mobility.

This is all in the backdrop of a criminalised state of being LGBTQIA+ in Sri Lanka. While Sections 365 and 365(A) of the Penal Code Ordinance are used as general clauses in criminalising homosexuality (especially cisgender individuals), Section 399 is specifically used to criminalise and arrest trans persons under the grounds of impersonation or cheating personation. Although efforts have been made to decriminalise LGBTQIA+ identities in the country, such narratives have been and continue to be subjected to political hijacking which results in zero progress. Section 365(A) was amended in 1995 by the Sri Lanka Parliament to read "gross indecency between two persons" leaving out "males" which was in the original text (Outright International, n.d.), effectively broadening the scope of the law beyond gay men. Although the legal status of other sexual orientation and gender identities/expressions is ambiguous, all LGBTQIA+ persons are generally treated more or less the same by law enforcement authorities (Human Rights Watch, 2016; United Kingdom Home Office, 2021).

Out-of-pocket expenses

According to the in-depth interview and the FGD, equipment for HIV/AIDS testing and drugs are provided for free by the government through the Global Fund – however, the respondents also revealed that government

⁷ This would include any behaviour, appearance through clothing, or physical features which are perceived to be transgressing the boundaries of heteronormativity. Such perceptions could lead to discrimination at the hands of cisgender, heterosexual individuals and/or groups (Kelly et al., 2021; Stella, 2012).

hospitals are currently going through a shortage of STD/STI testing equipment. With shortages in testing at government hospitals and due to lack of awareness, some individuals seek private healthcare. It was revealed that at a private hospital, it would cost a person around LKR5,500.00 to get a STD and/or HIV test done, and with the additional cost of a doctor or channelling fee, it would come up to about LKR8,000.00. In the absence of medical transition opportunities within the country, many trans persons have opted to get these surgeries done abroad or from private hospitals in the country. However, this only reflects an extreme minority as not every trans person is able to resort to such options. For instance, it was said that to channel a doctor at a private hospital for trans healthcare would cost around LKR11,000.00 and the total cost, including transition surgeries and drugs, would come to around two million LKR. Trans persons who are medically transitioning also have to bear other costs on medicine monthly, namely hormones if they are undergoing hormone replacement therapy (HRT). It was reported that before the COVID-19 pandemic, a person would spend around LKR10,000.00 on hormones and this cost has now come up to around LKR20,000.00 (FGD, H2H, 2023).

The COVID-19 pandemic and the following politico-economic crisis was especially difficult for the trans community, with the import restrictions placed on drugs. When medically transitioning, HRT is to be done regularly and hormones drugs were one of the drugs affected by this import ban. Not going through HRT regularly could result in medical complications and affects these individuals' day-to-day lives. For instance, one respondent said, "living with HRT is difficult. When you don't take hormones for 2-3 days, you feel like a person addicted to drugs; you can't eat, you can't go to the washroom. It's very hard" (In-depth, 2023). Before COVID-19, an oestrogen tablet was around LKR5.00 or LKR6.00 and one was able to purchase oestrogen for about LKR925.00 per

cycle. However, due to the imposition of import restrictions, this went up beyond LKR2,500.00 per cycle (In-depth, 2023). In the absence of oestrogen, many had used Mithuri instead; a birth control pill with very small amounts of oestrogen which can have negative side-effects on those who are undergoing HRT (In-depth, 2023). However, there were also contradictory responses saying that access to HRT was only difficult to those who were not attending the trans clinic officially but taking medicine after consulting their other trans friends who were actually attending the clinic (FGD, H2H, 2023).

Within the Sri Lankan legal framework, provisions have been made for trans healthcare, and this is mainly provided through General Circular No. 01-34/2016 issued by the MoH and No. 06 of 2016 by the Registrar General's Department (RGD). These circulars address the social, economic, and political marginalisation of trans individuals, and they aim to provide legal recourse for trans persons along with the opportunity to obtain a Gender Recognition Certificate. Individuals can change their name on their birth certificate and their National Identity Card. However, this is not without flaws, for although one can change their assigned gender at birth legally, the changed document would still include the gender assigned at birth as the previous gender, restricting these individuals' space to fully express themselves. The display of the previous gender would also create the possibility for these individuals' further marginalisation as it would markedly point these individuals out as transgender; a choice which should be given to the individual themselves and not to the state.

As explained in the first phase of the study (through the input provided by experts), in Sri Lanka, in order to medically transition, one needs the approval of two psychiatrists and once approval is given, persons would have to go through what is known as a real-life test. In this phase of the study too these findings were confirmed by the respondents, and the time

period of the real-life test now, according to the respondents, has come down from two years to six months, as there is an increased number of appeals to medically transition by more persons (FGD, H2H, 2023; In-Depth, 2023). Whilst the first phase explored the negative outcomes of the real-life test in how it could possibly enforce a universal experience of a trans identity, respondents of this phase of the study claimed that they agree with the medical practitioners in enforcing this test; the respondents believe that the bodily expression and identification of a trans person needs time for familiarisation or getting used to, and they were also aware of instances wherein individuals who had already medically transitioned having regretted their decisions (FGD, H2H, 2023). Since this is also a statement touted by transphobic, conservative groups in denying trans healthcare, especially in the global north (Matsuda, 2022; Schipper, 2022), perhaps more open discussions are needed to study the nexus between the freedom of gender expression, agency, and medical practice within the community and between the community and medical practitioners.

Another finding in relation to trans healthcare was the possibility of discrimination based on the location of the Navoyda clinic. Since the Mulleriyawa Base Hospital is known for its specialised care on mental health, some respondents expressed concerns regarding the public's perception of the Navodya clinic operating there and trans healthcare being provided alongside mental healthcare (In-depth, 2023).

Discrimination by service providers

As per the respondents, discriminatory practices by medical staff and minor staff have reduced over the years and they attribute this positive growth to the work that NGOs, community-based organisations (CBOs), development partners, and aid agencies, especially organisations such as the Global Fund, have done, and the rise of social media. The latter has provided a platform for LGBTQIA+ individuals to express themselves

and widen the discourse on queerness and acceptance for the public to see (FGD, H2H, 2023; In-depth, 2023). However, for over ten years these respondents had experienced much discrimination when accessing healthcare, and they still do to some extent;

"We were discriminated against at the STDs clinics. If we sat in a chair and then got up to move, they [hospital staff] would wipe the chair using Dettol immediately. It was such a big deal. Now when we go to the STD clinic, we have a good acknowledgement (In-depth, 2023).

"The doctors who are in their 60s-70s haven't seen such individuals [transgender persons]. One day a doctor asked me so many questions, like at an exam. Doctors are sensitive. Some doctors are homophobic (FGD, H2H, 2023).

Apart from such incidents, the respondents also revealed how a lack of understanding of sexual orientation and gender identity/expression and trans identities persists amongst medical practitioners;

"There is a doctor at the trans clinic, and he doesn't acknowledge transgender individuals if they haven't medically transitioned. He says that you have to medically transition in order to be acknowledged as transgender (FGD, H2H, 2023).

"In government hospitals, doctors still talk to us like this. If we sit in front of them, they would lean back further in their seat and talk to us maintaining distance (In-depth, 2023).

"Sometimes let's say (we) go for hormone treatments. When you are going to get the hormone treatment they would say things like 'this is a boy. This is a good person. How can he be a woman?' (In-depth, 2023)

It was also reported by the respondents that the expected discrimination at the hands of healthcare providers at times even deters LGBTQIA+ persons from accessing healthcare. This lack of understanding also manifests itself when treatment is provided to patients. During the in-depth interview, it was revealed that doctors at the trans clinic would expect persons waiting to transition to come to the clinic dressed as the gender they desire to be, i.e., if a person is a trans woman, they would be expected to come to the clinic "dressed as a woman", or in other words, wearing wigs, make-up, etc.. According to our respondent, the majority of trans persons are not financially stable nor safe to do such things when attending the clinic. This is especially true for trans sex workers. The individuals interviewed for the study were from organisations working at the grassroots level, where the majority of LGBTQIA+ individuals are poor. The majority of LGBTQIA+ persons in the country, especially trans persons, live away from their homes due to discrimination faced at the hands of their family members and other community members/neighbours. Those who still live with their families and their old neighbourhoods cannot afford to be 'visibly queer' where they could transgress the boundaries of normativity (Butler, 1988) and attend the trans clinic. Those who live in the city have difficulty in finding employment due to their queer and trans identities as they are shunned by employers. In order to make a living, many would then turn to sex work, and the income they earn would not be enough to attend these clinics as they are expected to for a while. Although organisations such as Trans Equity of Sri Lanka helps individuals by providing them a place to change their clothes in Colombo, and provide them with other accessories such as wigs, jewellery, and makeup (In-depth, 2023), the doctors and other medical staff still do not seem to understand the difficult situations in which individuals are placed when such demands are made, and it is even more difficult when service is denied to those who do not dress a certain way.

In addressing this lack of understanding and awareness, the respondents interviewed had already conducted awareness raising sessions for medical staff on communicating and dealing with LGBTQIA+ patients, especially those who are trans. However, the fact that the medical staff gets transfers to other areas of the country has proven to be a challenge in effectively and efficiently making meaningful change within the health sector. This results in losing progress made overtime and an absence of sustainability in the changes made. This is, however, not to say that these organisations have not made any change, for they have worked over the years to make things better for the community and continue to do so.

Sex work and access to healthcare

Findings in relation to sex work and healthcare in this study are mainly to do with trans women sex workers. Even though it was mentioned earlier, that individuals are forced to or compelled to take up sex work as the only option to earn a living, there are many individuals who take pride in their work and treat it as their lifeline and only help when no one else would help them (In-depth, 2023; FGD, H2H, 2023). The Global Fund continues to provide funds (although the project cycle is coming to an end) for organisations in procuring contraception, lubricant, etc. so that they could be distributed amongst those who need them but cannot afford, and amongst them are sex workers. Although many organisations and individuals work towards promoting safe sex amongst sex workers, according to our respondents, many sex workers still engage in unsafe sex (especially penetrative) either due to lack of awareness/education or the inability to afford necessities. Another obstacle in promoting more safe sex during sex work is the legality of it; although sex work (or prostitution as referred to in legal text) is not illegal in Sri Lanka, according to Chapter 32 the Vagrants Ordinance, Chapter 19 of the Penal Code Ordinance, and Chapter 43 of the Brothels Ordinance, soliciting and procuring

(including brothels) of sex work is illegal and outlawed (Penal Code, n.d.; Brothels Ordinance, n.d.; International Commission of Jurists, 2021). Although our respondents claimed that the sex workers whom they interact and work with are self-employed, rampant queer- and transphobia and discriminatory cultural practices have led to (trans) sex workers being arrested frequently. Even though they could be bailed out if they have access to legal help (often through CBOs), sometimes these individuals are framed for other crimes to make their prison sentence longer; for instance, planting drugs in their person once arrested. When imprisoned, trans persons are put in cisgender prison wards, resulting in trans persons placed in dangerous situations, and such imprisonment oftentimes leads to sexual assault. Even if a sex worker were to practise safe sex in their work, once imprisoned, they are vulnerable to contracting STDs/STIs, and even lifelong infections such as HIV/AIDS (In-depth, 2023). Whilst lack of awareness, inability to afford contraception, and constant run-ins with the police were cited as main reasons for the spread of STDs/STIs and even HIV/AIDS, the government STD clinics were praised for their service provision by the respondents. According to them, discriminatory practices at STD clinics are seldom heard of and the medical staff working at such clinics have no judgement against those who engage in sex work. However, sustaining services at these clinics is becoming increasingly difficult due to drug shortages and equipment shortages, widening the possibility of increasing rates of STDs/STIs amongst sex workers and the larger LGBTQIA+ community.

Discussion

When reading the findings against an equitable service provision, it is evident that majority of the services available for the LGBTQIA+ community are lacking in many ways. One of the main shortcomings of the health services provided for the LGBTQIA+ community is the absence of specialised mental health services

for the community. Whilst general mental health counsellors are available for services, they are not trained in identifying and providing services for the nuances within the community, especially given the fact that Sri Lanka has a history of pathologising queerness – both sexuality and gender identities (de Zoysa and Shackel, 2011). This need for dedicated queer mental healthcare provision is on the rise, given the fact that not a lot of services are available for LGBTQIA+ persons of the country. For instance, access to state funded and subsidised surgeries is now completely non-existent for trans citizens of the country. This in itself lacks equitable service provision, for the state is signalling that trans healthcare is not a priority of the state at all and that whoever requires services should be willing to spend two million LKR or more to access them, either within the country or abroad. This absence of services also points to a lack of understanding on the state's end of the necessity of trans healthcare and how essential these services are to one's person and identity. The global literature available points to the detrimental effects the absence of and poor healthcare would have on trans persons; a stronger link is found between lack of care for gender dysphoria and suicidal ideation (García-Vega, 2018). The same can be said for the availability of hormones for those who are medically transitioning. In the findings, it was evidenced that those who do not have access to hormones display behaviour of addiction and it also affects their day-to-day life with the inability to even do something as essential as using a washroom. Then it is evident that the absence of these specific healthcare services for the LGBTQIA+ community seriously affects their day-to-day functioning. If a country is to serve its citizens alike and be equitable in its service provision, it cannot afford to be selective in who gets access to healthcare and who does not.

The establishment of the main trans health clinic (the Navodya clinic) at the Mulleiryawa base hospital further adds to the mental health

concerns surrounding the LGBTQIA+ community. As mentioned earlier, Sri Lanka has a history of pathologising queerness and the establishing of a trans clinic next to the National Institute of Mental Health, further reinforces this narrative, and this sentiment was shared by the respondents as well; “even when I first went to the clinic, I checked everywhere at the hospital because it’s a mental hospital. So, they just thought that we have a mental illness” (In-depth, 2023). A related issue is the lack of understanding and education amongst healthcare practitioners, especially those working with transgender patients. The enforcing of a “dress code” based on a heteronormative understanding of gender identity may reinforce a harmful narrative of binary gender identities, and prohibit self-expression and identification of gender. This may also lead to the expectation of having a universal transgender experience, doing more harm than good to one who would still be figuring out themselves. Another important factor which this practice leaves out of the equation is the agency of the person medically transitioning, as they are forced to follow instructions of the “expert” or risk not receiving service. Apart from the negligence on the medical practitioners’ end, it also points to a lack of understanding on gendered self-expression and gender identities which goes beyond the heteronormative binary. This may stem from the fact that no formal training is provided for medical students in universities. Only those who may work at trans health clinics would receive some lessons, and yet even that is deemed to be insufficient by organisations working on health. Many organisations have attempted introducing modules on queerness and the LGBTQIA+ community for medical faculties to no avail (FGD, H2H, 2023). This also can be taken as an example of how the absence of equity in training results in an absence of equity in service provision.

The findings on queer and trans sex workers also reveals the convoluted nature of the legal framework of the country. As mentioned earlier,

the Sri Lankan legislature recognises the marginalised status of trans persons and provides somewhat of a space for gender reassignment on legal documents. This legality is supplemented then by the recent circular, referred to as IG’s Circular, 2740/2022 and Crime Circular, 03/2022, published in December of 2022 on Matters to be considered when dealing with transgender persons and persons who have undergone gender transition, where it clearly states that the Sri Lanka Police must abstain from inflicting harm (physical, verbal, and sexual) on trans persons and prevent from circulating misinformation during official trainings (I.G. Circular No. 2740/2022). However, as the findings suggest, trans individuals continue to be singled out by the police. Even when one is not engaging in sex work, it was reported that the police would verbally harass and arrest trans individuals simply by virtue of being trans (In-depth, 2023). Framing of such individuals and imprisoning them also shows the extent to which the sex worker community has been made a scapegoat whilst also raising the question as to how efficient the law enforcement authorities of the country are. In terms how this affects the LGBTQIA+ community’s access to health services, as mentioned earlier, unfortunately, these individuals end up as victims of sexual assault, exposing them to life threatening STDs/STIs. The convoluted nature of the legislature is further evidenced in the absence of absence of trans wards at hospitals and prisons; the former, according to respondents, has resulted in worsening patients’ condition as they had to wait until the hospital staff was figuring out how to admit the patient, and the latter creates unsafe and dangerous situations in which trans persons falling prey to sexual assault and STDs/STIs and even HIV/AIDS. This points to a clear mismatch and incoherence between policy formulation and implementation.

Lastly, the impact on paid healthcare for LGBTQIA+ communities needs to be paid more attention. As mentioned earlier in the

findings, many LGBTQIA+ individuals, due to discrimination, have moved away from their homes and families to more urban areas to find employment and live out their true identities. When doing so, the majority of them would resort to precarious work such as sex work. In case of an emergency, these individuals would not have the finances to channel consultants at private hospitals. Many of them would be spending their income on rent and other necessities, and as a result of moving away from their hometowns, they would not be recipients of the social welfare benefits. These individuals do not have permanent residence in where they would be working and if they were to apply for social welfare schemes, they would have to return to their hometowns where they would be denied service on the basis of their queerness or their work. In light of this, expecting LGBTQIA+ persons spend their own money in order to access basic healthcare needs is concerning and points to lack of fair, thoughtful, and equitable service provision.

Public-Private-Partnerships (PPPs) in health sector

Amidst the financial incapacities the government is facing at the moment, discussions on privatisation and PPPs are among the resolutions to the existing free health care in Sri Lanka.

Sri Lanka has witnessed the implementation of PPPs in various sectors, including ports, power generation, industrial parks, and telecommunications, as reported in both literature and surveys (Perera, 2016). However, it is important to note that the overall success of PPPs in Sri Lanka is considered limited. Despite the country's post-war development progress, there is a recognised need to further embrace PPP practices across various sectors. The government's intention is to elevate Sri Lanka to a strategic economic centre within the region, necessitating private sector participation through PPPs to expedite infrastructure project implementation and alleviate pressure on the government's budget. However, to achieve this, it

is crucial for the government to identify specific projects suitable for private sector involvement and create a conducive environment to actively engage private entities (Perera, 2016).

PPPs in the health sector have mixed reviews in existing literature as well as extracting from KPIs conducted in relation to the health sector. The possibility of PPPs hoping to address the feasibility of free health in Sri Lanka was looked into by Kumar (2019). While the study highlighted the shift from public financing to PPPs in the global arena, the possibilities of successful PPPs in the health sector is discouraged given the quality assurance as well as ensuring equity issues among less developed regions. Further, Narangoda and Khathibi (2014) in a survey identified that only 72% of health officers think PPPs as a feasible solution for sustainability of health care given that the private sector is often "profit driven" as opposed to ensuring quality in the services delivered. Pessimism exists not only with health officials, but also with the general public as well as the trade unions, who posit that PPPs while maybe a solution for other sectors, providing essential service such as health is not one of them.

Apart from the provisioning for PPPs, the expert consultation with an academic working on health policies and financing affiliated with the University of Colombo suggested feasible solutions to finance and ensuring the sustainability in the health care sector. For instance, she stressed the importance of being practical and methodical with the available budget while outsourcing services like scans and blood reports as well as other services such as cleaning that would not affect the services' quality. Furthermore, while emphasizing preventive care over curative care, the importance of Primary Health Care facilities plays a vital role in mitigating the cost for health care overall.

In conclusion, provisioning PPPs as an alternative to health financing is seen pessimistic evident by literature as well as industry expert.

Conclusion

The lack and absence of transparent and accountable governance in the estate sector has resulted in poor service provision for the Upcountry Tamil community. Even after 200 years of exploitative labour practices, the state and the estate management has failed to provide this community adequate, basic services. This community's sufferings seem to be placated by divisive party politics and unionising for their own benefit which has led to a mismanagement of fund and aid directed towards the benefit of this community. In terms of equitable provision of healthcare services for the LGBTQIA+ community of the country, the above discussion shows how there is both an absence of service provision and a lack of awareness amongst healthcare in dealing with the community. The legal framework surrounding services for the LGBTQIA+ community has made some provisions for healthcare, although they are largely limited to the trans community. However, these provisions seem to be convoluted with the

sections 365 and 365(A) of the Penal Code in effect. Attempting to create a legality within an illegality has led to an inefficient service provision and resulted in failure to change ideologies and reduce mis- and disinformation amongst healthcare providers. This has led to continued discriminatory practices by healthcare providers towards the LGBTQIA+ community and this has largely been due to historical pathologising of the LGBTQIA+ community and lack of awareness and educations. Although the legal provisions made to aid service provision for LGBTQIA+ persons exist within a larger framework which more or less nullifies the effectiveness of the provisions made. Financing and maintaining health as a free service has been challenged. The literature as well as KPI reveals that utilizing PPPs as a model to finance health is seen as a tough challenge that ensures equity and quality. However, sensible planning and outsourcing such as cleaning services are suggested to reduce the burden of sustaining health as a free service in the country.

Recommendations

(some of these recommendations are directly suggested by the consulted communities themselves)

Recommendations for the Estate sector/ Upcountry Tamil Community

- Estate dispensaries need to come under one management
 - There is a shortage of drugs and personnel working at Estate dispensaries and some EMAs would be working at multiple divisions at once, only allowing them to spend a few hours at each dispensary. Having one responsible entity could help streamline the functioning of these dispensaries.
 - Expand the cluster-based Primary Medical Care Units (PMcUs)
 - As explored in the first phase of the study, the PMcUs play a pivotal role in increasing access to subsidised healthcare for those who cannot afford to money for private healthcare. Having a dedicate cluster of hospitals that is responsible for one's wellbeing would also put less of a strain on the healthcare system by placing the responsibility mainly on divisional and base hospitals. In the absence of efficient Estate dispensaries, individuals could then turn to PMcUs instead of spending more than 1/3rd of their income on private healthcare.
 - Language proficiency for medical staff
 - This is crucially needed in areas where there are large populations of Tamil speakers. Although healthcare providers are given a general training on Tamil during their medical education, it is not repeated again once their service begins. Anyone who is stationed at a Tamil speaking area should be given adequate proficiency in the language for a better and more inclusive and equitable service provision.
 - This would be keeping with Article 22 of Chapter IV of the Constitution which has made provisions for citizens of the country to seek services in a preferred language, especially if the administrative language of that area is Sinhala (Sri Lanka Const. art. XXII, § 4). A mechanism should be put in place to maintain accountability in this regard, especially in areas where Tamil and other minoritised languages are spoken.
 - Implement free or subsidies meal programmes
 - As explained above, the Upcountry Tamil communities consulted could not afford nutritious food. This is further worsened for pregnant mothers and mothers of toddlers and infants who also do not receive thripasha. The state could provide nutritious meals to targeted pockets of the population; for instance, students in school, pregnant mothers and mother of toddlers and infants, the elderly, etc.
 - Arrange and conduct clinics at convenient times
 - The clinics conducted at government hospitals (or even estate dispensaries) are usually conducted on weekdays during work hours and this largely affects those who are daily wage workers, i.e., those working at the estate or nearby farms.
 - Given the issue of financing and sustaining health as a free service in the country, the Ministry of Health should allocate funds in a more systematic way.
 - Data collection and free access to health data should be encouraged. Access and collection of disaggregated data ensures more accuracy in terms of utilizing the scarce resource of funds.
- ## Recommendations for LGBTQIA+ healthcare
- In order to make meaningful change for the LGBTQIA+ community, the legal framework must change. The criminalised nature of LGBTQIA+ persons continues to maintain a negative and harmful narrative about the

gender and sexual identities of the LGBTQIA+ community amongst both the general public and the medical community. As a first step, passing the proposed bill on decriminalisation of homosexuality (along with all other forms of queerness, i.e., both gender and sexuality) would aid in this cause. Any hesitation in seeking healthcare, especially treatment for sexual and reproductive health, would improve, leading to more awareness, reducing incidents of further spread as well.

- The implemented provisions for queer healthcare must not be framed by a cis-heteronormative ideology. The nuances of self-expression of gender and sexual identities and the existence of and the performativity of queer gender identities must be understood by policymakers and medical professionals alike.
 - This should be especially done for trans healthcare. Individuals should not be expected to dress a certain way and certain gender and a person's agency should not be compromised during service provision.
 - The gender recognition and reassignment process for legal documentation should avoid mentioning one's dead name and gender. Provisions should also be made to include more gender identities in legal documentation instead of an 'other' option.
- Education and awareness on LGBTQIA+ persons
 - Health concerns faced by LGBTQIA+ persons and the ways in which they should be dealt with need to be introduced into the curricula of those who are in training to be healthcare professionals. This could commence as an extension of basic decency and respect when dealing with other human beings. Organisations such as the Global Fund and Heart to Heart have already been working on such issues, and partnering up with such organisations would also give the state an understanding of the ground reality. Sensitising medical professionals who are directly dealing with communities at the ground level is crucial.
- The existence of different gender and sexual identities should be introduced into the school curricula as a strategy of raising awareness, and changing discriminatory and violent attitudes and practices against the LGBTQIA+ community.
- Establish dedicated mental health services for the LGBTQIA+ community
 - As a community that faces discrimination on a day-to-day basis, mental health issues are a common occurrence within the community. However, due to lack of education and proper training, many mental healthcare providers resort to pathologising the patient's queerness instead. In avoiding this harmful practice, the state needs to update its medical faculties' curricula on mental health to meet international standards, based on scientific facts and evidence-based research, instead of on misguided, postcolonial cultural practices.
- Estate dispensaries require trained and qualified doctors and other medical staff
 - The communities request for MBBS qualified doctors so that they would feel safe during service provision. This would also prevent any unnecessary complications from taking place during service provision.
 - Estate dispensaries also require more medical staff in order to provide an efficient service to its patient population.
- STDs/STIs screenings for the general population
 - Apart from STD clinics, the only screening done for STDs/STIs is carried out by midwives for pregnant mother and this leaves out anyone else from the process, especially the men. Screening for STDs/STIs

for the general public would also help get a better picture of the spread of diseases. Oftentimes, LGBTQIA+ persons, MSM (queer men or prisons, for instance), and sex workers are treated as key population of STDs, and especially HIV/AIDS (National Aids Control Programme, 2022), leaving out a large portion out of the society who may be at risk of spreading the virus to others or being exposed to the virus.

- o Decriminalising provision of sex/sexual services could also help in reducing the spread of and incidents of STDs/STIs amongst the sex worker population. Either completely decriminalising sex work or only criminalising the purchasing of the service is service recommended. The latter, as seen in Sweden (implemented since 1999) , has resulted in less purchasing of sex work when compared to countries that do not (Jonsson, 2023).

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Appendix A

Full list of consulted persons

Type	Location	Number of Consultations	Parties Involved
Focus Group Discussion (FGD)	Kandy	1	Provincial and divisional level government officers working on health, transport, education; Members from PHDT
	Kandy	1	Institute for Social Development
	Kandy (Panvila)	1	Officers at the Divisional Secretariat; Midwives
	Kandy (Madulkele)	1	Medical staff and minor staff of the divisional hospital
	Battalagalla (Hatton)	3	The elderly; Men working in and around the estate; Young mothers
	Gordon Estate (Nuwara Eliya)	5	The elderly; Men working in and around the estate; Young mothers; The youth
	Spring Valley (Badulla)	1	The elderly; Men working in and around the estate; Young mothers; The youth
	Uduwara (Badulla)	1	Young mothers; The youth; Middle-aged women
	Colombo	1	Queer persons affiliated with Heart to Heart (identified as; 2 MSM persons, 1 trans woman, 1 queer person)
Key Person Interviews (KPIs)	Hatton	1	Industry expert
/Key Informant Interviews (KIIs)	Colombo	2	Industry experts/academics
In-depth interview	Gampaha	1	Executive Director of Trans Equity of Sri Lanka (identified as a trans woman sex worker)

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