

PEOPLE'S COMMISSION

on Pandemic Justice and the Right to Health

LAW & SOCIETY TRUST
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ACKNOWLEDGEMENT

The Law & Society Trust (LST) acknowledges with thanks the support received from the Catholic Agency for Overseas Development (CAFOD) to implement this project. We thank the Commissioners who generously gave their time to participate in this project, and we also thank the Citizens' Dialogue team from LST, who were responsible for the social media coverage of the project, especially the public hearings. We also thank our network of partners who coordinated and arranged the numerous public hearings and focus group discussions.

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ABBREVIATIONS

- CAFOD (Catholic Agency for Overseas Development)
- CKDu (chronic kidney disease of Unknown Etiology)
- FGD (Focus Group Discussions)
- FTZ (Free Trade Zone)
- LGBTI+ (Lesbian, Gay, Bisexual, Transgender, Intersex, and other identities)
- LST (Law & Society Trust)
- MOH (Ministry of Health)
- NAFSO (National Fisheries Solidarity Movement)
- NMRA (National Medicines Regulatory Authority)
- PWD (Persons with disabilities)
- WHO (World Health Organisation)

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EXECUTIVE SUMMARY

Key Findings from Public Hearings and Focus Group Discussions

This executive summary synthesizes the findings from a series of public hearings and focus group discussions held across Sri Lanka to document the profound impact of the Covid-19 pandemic and associated health system failures. The inquiry reveals a complex landscape of challenges, highlighting systemic weaknesses, inequities in healthcare, and the compounding effects of social, economic, and gender disparities. It offers targeted recommendations to strengthen Sri Lanka's public health system and ensure a more equitable and resilient response to future health emergencies.

Public Health Measures and Their Impact

Masks: Accessibility, Effectiveness, and Enforcement

- Masks were widely recognized as essential for curbing Covid-19 spread, yet accessibility was a major issue for low-income groups, with price hikes and shortages forcing many to reuse masks or fabricate cloth versions, often with limited effectiveness.

- Strict enforcement led to arrests and public discomfort, with coercive measures causing anxiety and resentment. Access to masks in Free Trade Zones (FTZs) was inconsistent, with initial provision giving way to shortages, compelling workers to purchase and reuse masks for extended periods.

Quarantine: Support, Enforcement, and Psychological Impact

- Quarantine measures varied widely; some benefited from adequate food and medicine, while others faced neglect, economic hardship, and emotional distress.

- Enforcement was often heavy-handed, with the military administering quarantines as punitive rather than supportive, leading to fear and confusion. Forced quarantines, sometimes without medical basis, deepened mistrust and highlighted the lack of empathy and training among enforcers.

Vaccination: Trust, Adverse Events, and Consent

Public Perceptions and Experiences

- Trust in vaccines was fragmented, with many expressing confidence in their efficacy and safety, while others reported adverse events and persistent fears. Claims ranged from infertility and new chronic illnesses to suspicions of fatalities.

- Information about vaccines was often inadequate or poorly communicated, exacerbating public distrust and resistance. Technical language, unclear consent procedures, and lack of follow-up contributed to confusion and hesitancy.

Coercion and Consent

- Vaccination became a mandatory prerequisite for access to hospitals, schools, workplaces, and public transport, eroding autonomy and privacy. Consent forms were regularly signed under pressure, sometimes without proper explanation or understanding, further highlighting the coercive nature of the rollout.

- Alternative treatments, such as Ayurvedic "green cards," gained traction as institutional gaps persisted, reflecting a shift in community trust and strategies for navigating official mandates.

Handling of Covid-19 Deaths

Disposal Policies and Religious Rights

- Forced cremation policies denied families the right to conduct religious burial rituals, causing deep pain and distress, particularly among Muslim, Hindu, and Christian communities. Participants described irreparable emotional wounds and a persistent sense of injustice.

- Rapid disposal extended beyond confirmed Covid deaths, affecting those who died from unrelated causes, underscoring the arbitrary and sweeping nature of the policy.

Health System Failures and Inequities

Inequality in Healthcare Delivery

- Longstanding disparities in public hospitals became starkly visible during the pandemic, with poor, ethnic minorities, and marginalised groups receiving substandard care. Social status and language barriers influenced treatment quality and outcomes.

- LGBTI+ and disabled individuals faced neglect, invasive questioning, and lack of culturally competent care, reflecting the need for greater sensitivity and inclusivity within health services.

Shortages and Privatisation

- Public hospitals struggled with shortages of medicines, equipment, and staff. Patients were routinely directed to private clinics, often by the same doctors, leading to increased out-of-pocket expenses and deepening social divides.

- Chronic patients, including those with cancer and kidney disease, were especially affected. Delays and limitations in non-Covid care compromised outcomes and heightened frustration.

Administrative Failures and Negligence

- Negligence, misdiagnosis, and procedural errors were common, eroding public trust. Participants reported mixed samples, incorrect prescriptions, and a lack of effective grievance redress mechanisms.

- Corruption and influence of "medical mafias" in drug supply chains were openly discussed, with many believing that institutional distrust and fear of reprisal deter complaints.

Gendered and Marginalised Group Impacts

Women and Domestic Violence

- Lockdowns led to an increase in domestic violence, with heightened tensions and substance abuse exacerbating household abuse against women and children.

- Women's health was neglected, with lack of access to sanitary products, mistreatment during obstetric care, and punitive attitudes toward pregnant women.

Persons with Disabilities, LGBTI+, and FTZ Workers

- Disabled persons faced additional barriers due to inaccessible facilities, language barriers, and lack of support services in hospitals.
- LGBTI+ individuals experienced heightened discrimination, police violence, and economic hardship, sometimes turning to sex work for survival.

- FTZ workers endured overcrowded living conditions, lack of health facilities, inconsistent enforcement of health measures, and continued mental health challenges due to isolation and financial stress.

Mental Health

- Mental health issues surged as families coped with isolation, loss of income, and the absence of institutional support. Civil society organizations provided some counselling, but the public health response remained inadequate.

Impact on Livelihoods

- Lockdowns devastated livelihoods, especially among informal sector workers and marginalised groups, plunging many into debt and economic insecurity.

- Government relief programmes were unevenly distributed, failing many vulnerable groups. Community solidarity often filled gaps left by systemic failures, with traditional medicine and local support networks providing crucial assistance.

Recommendations

Structural and Systemic Reforms

- Adopt a multidisciplinary approach to healthcare, integrating sociology, psychology, and law into public health responses. Strengthen and invest in local and traditional medical systems, food safety research, health education, and communication in all official languages.

- Empower communities by fortifying civil society organizations and grassroots health advocacy. Increase training for health sector workers in empathy, communication, and ethical consent procedures, ensuring patients understand treatments and medications.

- Establish and widely publicize confidential complaint mechanisms, including the 1907 hotline and dedicated institutions to address malpractice and health injustices.

Hospital and Government Reforms

- Form active Hospital Development Committees involving citizens. Improve transparency about government decisions, retain medical professionals, and prioritize supply of quality medicines and sanitation reforms.

- Ban dual practice of government doctors in private clinics; address unethical practices and guarantee accessible, affordable healthcare.

Post-Vaccine and Pandemic Responsibilities

- Conduct rigorous investigations into vaccine side effects; ensure transparency and compensation for victims of forced cremations and other injustices.

- Review and improve protocols for public communication, consent, deployment of military, and delivery of social support, with special attention to livelihoods, gendered impacts, disability access, and sexual minority concerns.

Long-Term Improvements

- Create a network of low-cost healthcare alternatives and inter-agency committees for education and monitoring, especially in FTZs.

- Rebuild trust in public healthcare and education; resist privatization of healthcare in accordance with IMF agreements to protect the right to health for low-income populations.

Conclusion

The Covid-19 pandemic laid bare the deep-rooted structural failures, inequities, and vulnerabilities in Sri Lanka's healthcare system and society. The voices from public hearings and focus group discussions underscore the urgent need for holistic reform, ethical governance, and community empowerment to ensure health equity, dignity, and resilience for all Sri Lankans.

INTRODUCTION

The Covid pandemic stands as one of the defining global crises of the twenty-first century—a maelstrom that disrupted societies, shattered economies, and magnified longstanding inequities in every corner of the world. In Sri Lanka, the pandemic posed a challenge to the public health system while illumining with unforgiving clarity, the deep-rooted structural vulnerabilities, social disparities, and governance failures embedded within the nation's fabric. As the virus swept across the island, it wrought a health emergency and tested collective values: justice, equity, dignity, and the social contract itself.

This report emerges from the lived experiences, testimonies, and reflections of Sri Lankans from all walks of life. It draws on a diverse array of voices heard at public hearings, focus group discussions, and community consultations conducted across districts and social strata. By weaving together personal narratives with policy analysis, the report aspires to chart a course towards holistic reform, ethical governance, and genuine community empowerment in the aftermath of the pandemic.

Beyond the immediate strain on hospitals and clinics, the pandemic exposed the myriad ways in which health is inseparable from broader social determinants: livelihood, education, gender, disability, and social status. The crisis made visible the hidden contours of marginalization and exclusion. Those living in Free Trade Zones (FTZs), daily-wage earners, sexual and gender minorities, persons with disabilities, and rural populations encountered distinctive challenges—from lack of access to protective equipment, medical supplies, and information, to heightened exposure to economic and social harms.

This report is rooted in the conviction that effective public health responses must be grounded not only in data and policy, but also in the lived experiences of those most affected. Through public hearings, focus group discussions, and a range of community consultations, the research gathered here centres the voices of frontline workers, daily wage earners, sexual and gender minorities, persons with disabilities, rural communities, and those living in Free Trade Zones (FTZs)—groups who often face compounded vulnerabilities during crises.

The aim of this report is twofold. First, it seeks to document and analyse the key lessons of Sri Lanka's Covid response, highlighting both failures and innovations. Second, it aspires to chart a path forward—one that prioritises health equity, ethical governance, and community empowerment. The findings and recommendations presented herein are not just intended for policymakers and practitioners, but for all Sri Lankans who care about justice, dignity, and the right to health.

The pandemic struck at a time when Sri Lanka was already grappling with the aftermath of decades of civil conflict, persistent poverty, natural disasters, and a public health system under sustained strain. Against this backdrop, Covid acted as a magnifying glass, intensifying the pressures on already overstretched hospitals and clinics, exposing gaps in the delivery of essential medicines, and revealing the limits of existing social protections.

Yet, the crisis also demonstrated the resilience and ingenuity of Sri Lankan communities. Across the country, individuals, families, and grassroots organisations mobilised to care for the vulnerable, share scarce resources, and demand transparency and accountability from authorities. These collective efforts, though too often hampered by bureaucratic obstacles and inconsistent policy, provide invaluable lessons for future health emergencies.

The Covid pandemic underscored the reality that health cannot be separated from broader social determinants—income, education, gender, disability, and social status, all of which shaped people's experiences of risk and resilience. The crisis revealed how denial of access to information, essential supplies, and meaningful participation in shaping

pandemic responses undermined trust in public institutions. It illustrated, too, that top-down, coercive approaches to public health—such as mandatory mask enforcement without adequate provision of masks or support—risked deepening exclusion and stigmatisation.

This report takes as its starting point the principle that health is a fundamental human right, and that realising this right requires more than a technocratic response to disease. It calls for genuine accountability, participatory governance, and sustained investment in public systems that protect the most vulnerable.

In seeking a holistic understanding of Sri Lanka's pandemic response, the report employs a mixed-methods approach. Quantitative data, drawn from official statistics and epidemiological studies, is complemented by qualitative insights from those at the sharp end of policy failures and successes. Public hearings and focus group discussions spanned urban and rural areas, encompassing a diversity of ages, occupations, and identities. Testimonies were collected in multiple languages to ensure inclusivity and cultural relevance.

The analytical framework for this report is grounded in principles of equity, participation, and justice. Rather than focusing solely on what went wrong—or right—in policy terms, it interrogates who benefited, who was left behind, and why. It pays particular attention to the intersectional impacts of the pandemic: the way gender, disability, class, and other social factors combined to shape people's access to health and social support.

The findings and testimonies collected for this report paint a picture at once sobering and hopeful. They reveal the urgent need for ethical governance and community empowerment, for reforms that go beyond technical fixes and address the root causes of exclusion and vulnerability. As Sri Lanka moves forward from the pandemic, there is a unique opportunity to forge a new social contract—one that enshrines the right to health, prioritises equity, and builds resilience for future generations.

Ultimately, this report is both a record of a nation's ordeal and a blueprint for transformation. It is a call to action to ensure that the lessons of Covid do not go unheeded, and that every Sri Lankan—regardless of income, identity, or ability—can claim their right to health, dignity, and social justice.

METHODOLOGY

The Law & Society Trust established the "People's Commission of Pandemic Justice and Right to Health" to explore people's experience and perceptions on their right to health, and to support community organizations to seek reforms and accountability by conducting public consultations. The broader objective of this project was to explore the impact of Covid pandemic and subsequent economic crisis on people's right to health mainly from the people's perspective.

The specific research questions focused on through this project included:

- How is the right to health understood by people in the context of the pandemic?
    - Did it encapsulate mental health, wellness, chronic disease, palliative care, emergency care, maternal health, reproductive health, children health, elders' health care etc.?
- How do people perceive their rights protection in this extraordinary period?
- How do people perceive responsibility to protect these rights?
- Is it with the State, family, personal responsibility or other?

In the context of the pandemic the problem identified was twofold. Firstly, there was no reliable knowledge base on the full extent of the health experiences, including violations of the right to health resulting from pandemic-related policies. Secondly, victims of such violations need support to organise themselves to pursue accountability and reforms.

The project aims to raise awareness of such violations, reform needs and possibilities for such reforms based on the public hearings and focus group discussions by disseminating the project findings as reports, infographics and pictorial representation through mainstream and social media. Rights violations are documented with a view to engage the state with the community's lived experiences and in their efforts to pursue accountability formally, whether on an individual or collective level. Most importantly the project aims to engender reforms, not only of the health sector but in the ways that governments approach a plethora of crises and disasters.

The Covid pandemic and the economic crisis had an uneven impact on people's right to health depending on their livelihood, geographical location and other factors such as gender, ethnicity, age and social class. To interrogate the impact of Covid, the methodology adopted by the project team included: developing a survey questionnaire to grasp people's perceptions, preferences and priorities in terms of right to health. The survey itself involved designing the questionnaire, training survey investigators in the conduct of the surveys and compiling the findings. The preliminary survey was carried out with a randomly selected sample through the existing contacts.

The planning and preparations for the consultations and discussions included determining who was to be consulted, where the consultations would be conducted (sites of consultations) and how (the manner of reaching out to the public) the consultations would be conducted.

The project adhered to the ethical aspects of the research and the conduct of public hearing, following the due process – i.e., obtaining the ethical clearance for the research from the University Ethics Committee.

Ethical approval (RECSSH/2024/06) for the research was obtained from the Research Ethics Committee for Social Sciences and Humanities, Faculty of Arts, University of Colombo.

The team took additional measures to ensure confidentiality and safety of the participants, including securing consent prior to filming or photographing participants. Furthermore, the team undertook a risk analysis and the project team arranged for counsellors to stand-by to attend to any emotional or psychological issues of participants attending the hearings as a result of revisiting or recalling their experiences during the hearings. Translation was provided and a set of protocols were developed to prepare the Commissioners in the conduct of the hearings and to maintain the flow of the consultations. (Annex 3 for consultation protocols)

The sites for public consultations were selected primarily based on people's livelihood sectors, social status and their geographical distribution. Accordingly, public consultation sessions were organized targeting different livelihood sectors including but not limited to farming, fishing, plantation workers and apparel workers geographically representing all provinces. When organizing these public consultations (public hearings and focus group discussions) the team ensured that participants are representative in terms of gender, ethnicity and age. Necessary actions were taken to ensure the participation of people with disabilities, sexually marginalized LGBTIQ people, and indigenous and elderly people to understand the intersectionality and the compounded impact of Covid measures on such persons.

Public consultations were carried out for 6 months from June 2024 to November 2024 covering all provinces in the country (see Annex 3). Accordingly, 13 public hearings conducted (Annex 3) in Jaffna, Vavuniya, Mannar, Batticaloa, Kandy, Nuwara Eliya, Bibile, Ampara, Deraniyagala, Anuradhapura, Kurunegala, Colombo and Galle. In parallel to public hearings, 18 focus group discussions (Annex 4) were conducted with diverging social groups including farmers (male and female), fishers (male and female), estate workers, people with disabilities, LGBTIQ people, indigenous people, chronic kidney disease patients, garment workers and health-sector workers (see Annex 4). Please see Table 1 for a

breakdown of focus group discussions in each area. Each public hearing was conducted by at least one Commissioner (in most cases 2-3 Commissioners) and FGDs were conducted by the Commissioners as well as the lead researcher depending on the situation. Public hearings were attended by participants ranging from 30 – 65 depending on the organizing capacity of the coordinators and enthusiasm of the participants.

Table 1 : Breakdown of focus group discussions

Area	Social group
Jaffna	LGBTIQ community (Tamil) PWD (Tamil)
Vavuniya	Women farmers (Tamil)
Mannar	Fishers (Tamil) PWD (Tamil)
Batticaloa	Women Fishers (Tamil) People affected by the cremation issue (Muslims)
Mahiyanganaya	CKDu patients Women Farmers (Sinhala)
Nuwara Eliya	Vegetable farmers (Tamil) Estate workers (Tamil – male) Estate workers (Tamil – female)
Bibile	Farmers (Sinhala; male and female) Indigenous community
Ampara	Healthcare workers (Tamil)
Anuradhapura	Healthcare workers (Sinhala)
Galle	Healthcare workers (Sinhala)
Katunayake	Garment workers (female)

SUMMARIES OF THE DISTRICT LEVEL MEETINGS

In Jaffna, the Commission conducted a public hearing and two focus group discussions with – people with disabilities (PWD) and the LGBTIQA+ community. The public hearing was attended by 65 participants (62 females, 3 males). All participants were Tamil-speaking and residents of the Jaffna and Kilinochchi districts. While the majority of attendees were members of civil society organizations, others included representatives from the Divisional Secretariat, health officers and farmers. The focus group discussion with people with disabilities was attended by 19 participants (8 males, 11 females) and the majority of participants reported that their disabilities were a result of war or polio. The discussion with the LGBTIQA+ community was attended by 17 participants.

Access to health care, quarantine and isolation issues, mistrust of the vaccinations, gender and disability discrimination and livelihood and economic challenges were at the fore front. The poor standards of medical facilities and infrastructure were also raised.

In Vavuniya, the Commission conducted a public hearing and a focus group discussion with women farmers in Nedunkerni. The public hearing was attended by 44 participants (41 females, 3 males) including both Tamil and Sinhala-speaking participants. While the majority of attendees of the public hearing were members of civil society organizations, others included representatives from the Divisional Secretariat, health officers, teachers and farmers. The focus group discussion with women farmers in Nedunkerni was attended by 14 female participants.

Recommendations from participants from the Vavuniya District included:

- Ensuring availability of essential medicines in all government hospitals
- Training healthcare workers in patient dignity, especially for maternity care

- Developing multilingual hospital communication systems
- Establishing fast-track mechanisms for maternal and paediatric emergencies
- Creating an independent patient grievance mechanism to address hospital mistreatment
- Prioritizing free and equitable healthcare access, especially for low-income communities

In Mannar, the Commission conducted a public hearing and two focus group discussions with a fishing community and people with disabilities (PWD). The public hearing was attended by 43 participants (36 females, 7 males) and all of them were Tamil-speaking. The participants for this public hearing came from a diverse range of backgrounds. They included Sociology undergraduates (four male and one female Muslim students), social workers, female daily wage labourers, self-employed individuals (sewing and bag/slipper making), a grocery shop owner, a Samurdhi Association member, a Civil Society Organization member, a preschool teacher, female farmers (one also self-employed in food preparation), a Nagara Sabha member (urban council member), a teacher, and several fishermen. A female member of the National Fisheries Solidarity Movement (NAFSO) also attended. The focus group discussion with a fishing community was held in Silavathurai, which was attended by 35 participants (12 females, 23 males). The participants were predominantly involved in fishing-related work, while the women also engaged in tailoring, managing small grocery shops, and house care work. The discussion with people with disabilities was held in Adamben, with the participation of 13 people (8 females, 5 males), and most of them were war-affected PWDs with impairments such as visual, leg, and arm disabilities. Across public hearings and FGDs, a consistent grievance emerged around public healthcare inaccessibility, negligence by medical staff, and treatment delays — particularly for non-Covid cases, the elderly, pregnant women, and disabled individuals.

In Nuwara Eliya, the Commission conducted a public hearing and three focus group discussions: estate workers – female, estate workers – male, and vegetable farmers. The public hearing was attended by 76 participants (44 females, 32 males) from diverse backgrounds including vegetable farmers, estate workers, social activists, teachers, pre-school teachers, students, healthcare workers, elders, government workers, domestic workers, construction workers, trishaw drivers and small business owners. All of them are Tamil-speaking. The focus group discussion with male estate workers attended by 15 participants, while the discussion with female estate workers was attended by 18 participants. There were 18 participants (both male and female) in total attended the focus group discussion with vegetable farmers which was held in Kandapola area.

Recommendations and suggestions proposed by the participants Nuwara Eliya District included:

- Strengthening informed consent processes by developing multilingual consent protocols that are clear and ensuring that individuals understand the risks, benefits, and rights related to vaccination;
- Establishing grievance mechanisms for redress;
- Creating a transparent system to report vaccine side effects;
- Offering medical follow-up and compensation when appropriate;
- Address discrimination and cultural insensitivity by training healthcare providers in cultural competence and non-discriminatory practices and employing more Tamil-speaking healthcare workers in estate areas;

- Rebuild public trust through community engagement by facilitating open dialogue between health authorities and communities and co-designing health campaigns with local leaders and civil society groups;

- Ensure equitable access to healthcare by decoupling essential services from vaccination status and guaranteeing access to hospitals, schools, and workplaces regardless of vaccination history.

In Addalachchenai, Ampara, a public hearing and a focus group discussion with healthcare workers were conducted by the PCPJ. The public hearing was attended by 45 participants including both Tamil and Sinhala speaking participants. Participants spoke candidly about healthcare challenges, cultural and religious injustices, economic impacts, and the militarization of pandemic responses. The discussion highlighted systemic failures and the community's resilience in the face of adversity. The focus group discussion with healthcare workers was attended by 6 participants including a couple of public health inspectors, a midwife and a hospital attendant. Participants shared their perspectives on managing public health challenges, handling resource shortages, and dealing with public resistance, as well as the emotional and physical toll of their roles.

Recommendations made by participants Ampara District included:

- Enhancing resource availability: Ensuring adequate protective equipment, medicines, and operational supplies.

- Fostering public awareness: Educating communities about healthcare rights and pandemic or emergency protocols.

- Building public trust: Improving transparency and communication to address societal fears and resistance.

- Supporting healthcare workers: Providing mental health resources and address systemic barriers to their work.

In Kandy, a public hearing was conducted by the People's Commission on Pandemic Justice and Right to Health which was attended by 44 participants (28 females, 16 males) including both Sinhala and Tamil-speaking participants. The participants came from a diverse range of backgrounds including domestic workers, three-wheel drivers, plantation workers, social workers, self-employed, members of unions and teachers. They also spoke of Covid vaccine side effects, apathy of health sector workers, drug shortages and referrals to private hospitals and clinics. They wanted greater accountability.

In Batticaloa the Commission conducted a public hearing and two focus group discussions: with women affected by the forced cremation issue and a fishing community. The public hearing was attended by 40 participants, all are Tamil-speaking, representing a broad demography, including social workers, public health workers, students, and housewives. The women FGD was attended by 6 Tamil-speaking women whose close family members were subjected to forced cremation. The FGD with fishing community was attended by 16 fisher women, all of them were Tamil-speaking.

The key issues discussed related to the coercion and confusion around the vaccine, health rights violation experienced by the community including misinformation and their consequent distrust of the system; the trauma experienced with forced cremations gender-based discrimination and marginalization and the loss of education for the youth. But they also spoke of community resilience and empowerment.

Participants from the Batticaloa District called for structural reforms and health justice.
They articulated visions of health justice—emphasizing the right to: free and timely treatment; non-discriminatory care, recognition of sanitation workers as health sector workers; and access to accurate and transparent health information. They expressed concern

over contamination of medicines and basic commodities and there was strong criticism of the privatization of healthcare.

In Anuradhapura the Commission conducted a public hearing and a focus group discussion with healthcare workers. The public hearing was attended by 28 participants (21 female, 7 male) and all of them were Sinhalese. The participants of this public hearing came from a diverse range of backgrounds. Among them were a retired health care officer, a teacher (female), a geography graduate (one student), social workers, farmers, daily wage labourers, self-employed persons (tailoring and bag/sandal making), a vegetable shop owner (female), Garment workers (women), a domestic worker based in Cyprus, self-employers, businessmen, grocers, housewives, and school students (two females and two males). The focused group discussion with healthcare workers was attended by 9 community healthcare workers (1 female, 8 male) including trade union members, public health inspectors, nurses (both male and female), a pharmacist and civil society activists.

As several participants Anuradhapura District pointed out, this forced and opaque approach to vaccination eroded public trust in an already struggling health system and exposed structural gaps in public health literacy and institutional accountability. They also noted that Citizen's lacked autonomy in medical decisions and there was no transparency in government communication.

Participants from the Anuradhapura District recommended:

- Conduct of community-based research on post-vaccine health outcomes from a multidisciplinary approach;
- Ensure ethical consent processes in all future vaccination or health programs;
- Launch awareness programs in local languages to clarify vaccine benefits and risks;
- Training health workers in empathetic, rights-based public engagement; and
- Restoring autonomy to health regulatory bodies, free from political interference.

In Colombo, a public hearing was conducted by the Commission which was attended by 26 participants (18 females, 8 males). The participants included community workers, students, parents, and postal workers, with a majority being middle-aged women. The event created space for individuals to reflect on their personal struggles, losses, systemic barriers, and the resilience shown during the pandemic. Themes explored ranged from healthcare failures to economic collapse, vaccine side effects, and social stigma.

A pervasive theme throughout the hearing was the widespread disillusionment with the public hospital system, where people described experiences of negligence, unavailability of medicine, financial exploitation, and lack of accountability. The participants, especially those from economically disadvantaged backgrounds, expressed feelings of helplessness, fear, and betrayal by a system that failed them during crisis.

From the Colombo District participants recommended:

- Establishing grievance redress mechanisms in all public hospitals
- Regulating dual practice and unethical referrals to private clinics
- Providing essential medicines and equipment to public hospitals
- Conducting public awareness campaigns on patient rights
- Developing low-cost healthcare alternatives for economically vulnerable families and
- Improving hospital transparency and introducing feedback systems

The Commission conducted a public hearing in Deraniyagala in the Kegalle district, which was attended by 31 participants (14 female, 17 male). Tamil is the native language of all participants, but most of them could understand Sinhala as well.

Vaccination was one of the most debated topics in Deraniyagala. Participants expressed a spectrum of experiences—from gratitude and belief in the vaccine to deep mistrust, fear of side effects, coercion, and even grief. Concerns were particularly acute regarding the third dose, with multiple testimonies alleging serious physical decline or even death following vaccination.

A public hearing was held in Galle with the participation of 29 participants (19 female, 10 male). This session gathered insights from a diverse group of community members—female social workers, health workers, public servants, journalists, and local leaders—who spoke ab Participants' recommendations Galle district

The Galle public hearing vividly illustrates the complex realities surrounding the Covid vaccine rollout in Sri Lanka. Misinformation, coercion, uneven distribution, and lack of public health communication contributed to widespread fear and resistance, particularly among poorer and rural communities. Simultaneously, the government's heavy-handed enforcement led many to feel stripped of agency, undermining trust in public health institutions.

Despite these challenges, participants also acknowledged the vaccine's life-saving role and the critical importance of informed decision-making. Moving forward, inclusive, transparent, and respectful health communication strategies are essential, as is recognition of alternative knowledge systems. Instead of dismissing them, there is a need to bridge them with scientific understanding to contribute to a wholistic crisis response.

Recommendations of participants from Galle included:

- Launching community-centred vaccine awareness campaigns involving trusted local leaders;
- Establishing legal and ethical frameworks to prevent coercion in future health interventions;
- Integrating scientific health information with culturally sensitive communication;
- Monitoring and evaluating vaccine side effects transparently, with public accountability
- Recognizing the emotional harm caused by vaccine coercion and isolation and build trust through dialogue and education.

In the Badulla and Monaragala Districts (Bibile and Mahiyangane the Commission organized public hearings). In Bibile the participation of 54 participants (34 females, 20 males). included many civil society organizations including Akiriyankumbura Farmers' Association, Uva Wellassa People's Rights Association, Hasalaka Farmers' Association, Siriliya Farmers' Association, Badulla Small Tea Estate Owners' Association, Wikalpani National Women's Association, Siyambalanduwa Ekabadda Youth Association, Wellassa Haritha Mithuro Association, Wellassa Society of the Disable Peoples and Bibile Model Infant Education Institute.

The Bibile and Mahiyanganaya hearings vividly expose the fragility and inequality of Sri Lanka's rural health system. Communities are struggling with doctor shortages, medicine inaccessibility, institutional corruption, and economic precarity, all intensified during the Covid crisis. While there were moments of resilience—like community care and postal deliveries—the overall sentiment was one of abandonment. The testimonies demand urgent reforms in rural health infrastructure, price regulation, and systemic accountability, particularly for chronic

disease patients who continue to be overlooked in national recovery efforts.

In parallel to the public hearing, three focus group discussions also conducted: with chronic kidney disease unknown etymology (CKDu) patients in Mahiyanganaya; with a farmer group in Ekiriyankumbura, Bibile; and with an indigenous group in Rathugala. The FGD with CKDu patients was attended by 18 kidney patients from Hebarawa, Wiranagama, Ginnoruwa areas and they were taking medical treatments for kidney issues from 3 to 17 years. The FGD with farmers in Ekiriyankumbura was attended by a group of 13 farmers who are engaged in paddy farming, corn, banana, coconut, agarwood, peanut cultivation as well as dairy farming, gardening and self-employment. Rathugala indigenous community meeting was attended by 19 Veddah community members including the community leader, Sudaa Wannila Aththo.

Recommendations from the Bibile and Mahiyanganaya community hearings included:

- Deploying kidney specialists in rural hospitals like Girandurukotte;
- Improving hospital staffing and accountability mechanisms;
- Ensuring consistent supply of essential medicines to rural clinics;
- Institutionalizing postal medicine delivery for remote patients;
- Preventing dual practice of doctors between private and public sectors; and
- Introducing community complaint systems with safeguards for patient anonymity.

A Focus Group Discussion (FGD) with Katunayake Free Trade Zone (FTZ) workers was conducted at Shramabhimani Centre, Katunayake to explore the impact of pandemic on the with a particular focus on transportation restrictions, poor quarantine conditions, vaccine accessibility, food insecurity, mental health neglect, and the failure of institutional healthcare systems. The centre is actively advocating for the rights of apparel workers who are considered as one of the most marginalized working sectors in Sri Lanka. The session was attended by five members of the organization.

The Katunayake discussion brings to light the deep structural neglect of Free Trade Zone workers in Sri Lanka during the pandemic. While factories thrived, workers were denied the most basic rights to health, safety, and dignity. Overcrowding, forced quarantines, allowance cuts, mental health crises, and poor medical infrastructure were just a few of the systemic failures identified. Where the government and employers failed, civil society stepped in,but stop-gap efforts are no substitute for long-term structural protections. If Sri Lanka is to uphold the health rights of its industrial labour force, it must institute reforms that centre worker agency, institutional accountability, and universal healthcare access, especially in times of national crisis.

Key issues discussed in the Katunayake Free Trade Zone included: The workers unsafe living and working conditions, inconsistent implementation of health measures, persistent health issues of workers and the poor services they receive. They noted that food poisoning was common among workers, there were only two Public Health Inspectors (PHIs) serve a population of nearly 50,000 workers and Medicare services were limited to those enrolled in insurance programmes but others had to buy medicines out-of-pocket. There were no hospitals nearby for immediate or serious cases.

The Katunayake Free Trade Zone workers talked of the psychological toll of Covid, the quarantine process including the military involvement in the quarantine and vaccination processes. Their recommendations included:

- Structural reforms in industrial health governance;

- Creation of inter-agency health committees with Ministry of Health (MOH), Labor department, civil organizations);

- Establishing factory-based health monitoring teams, led by workers; and

- Implementing a formal social protection system for workers in industrial zones.

MASKS

Issues with accessibility and effectiveness

Masks were globally mooted as an essential precaution against the spread of the virus and soon, many in Sri Lanka came to recognise the wearing of masks as a vital, collective responsibility, particularly in public spaces, and welcomed the strict enforcement of mask-wearing from very early on.

However, the increased demand for masks caused significant price hikes and shortages, making it difficult for various individuals, groups, and communities from low-income backgrounds, including daily-wage earners and people in the rural sector, to access proper masks. When wearing masks in public became mandatory, many resorted to reusing disposable masks or creating cloth masks to adhere to regulations, despite the obvious limitations in their effectiveness. Participants reported significant challenges related to mask distribution during the Covid pandemic and discussed how there were even arrests of people who could not wear masks in public or in their lines of work. Participants with children recalled how many of them took reusable masks to school.

A middle-aged male participant from Mannar District recalled how, "In schools, even if the child didn't have something to eat, they had to wear a mask and use sanitiser, which we couldn't afford." Another participant, a female participant from Mannar, recalled, "We washed our children's masks for them to wear when they go to school. In our household, we have about four to five kids. We asked them to carefully bring the masks from school, then we washed and dried them to wear again. We were struggling to even get food at that time and couldn't afford to buy disposable masks every day for our kids or for hospital visits." A female social worker from Kegalle said, "During the pandemic, we were required to wear a mask while working in the field, as it was a necessary safety measure. But we didn't have the means to by proper masks, they were often expensive because of the shortage. As a result, I had no choice but to wear a cloth mask. While it allowed me to comply with the requirement, it was not as effective as a surgical mask."

Wearing of masks was coercive and arbitrary

As many participants pointed out, despite the above difficulties in access and the ineffectiveness of the reusing cloth masks, people without masks in public were frequently seen being arrested in the media, causing them to wear such masks out of fear. Some participants recounted how they wore masks despite physical discomfort, such as the participant who wore masks despite difficulties with breathing. Other participants complained of general discomfort and unfamiliarity with wearing masks, especially when they were working. As a young, male participant from Deraniyagala said, "I don't want to wear a mask because it's uncomfortable for me, but I continued to wear one because a health official reprimanded me for going out without it. Despite my reluctance, I wear the mask to avoid facing further criticism or potential consequences, as I understand the importance of following health guidelines. However, the experience has been frustrating, as I feel compelled to wear something that I find uncomfortable, simply to comply with regulations."

In the Free Trade Zones, masks were initially provided free of charge. However, according to the focus group discussions with FTZ workers, after some time, companies stopped supplying

masks for free. A few civil society organizations stepped in to provide free masks, but the quantity was insufficient. As a result, workers had to purchase masks on their own and often reuse them for extended periods. A

QUARANTINE

Quarantine was imposed without adequate support

Participants recalled mixed experiences with how isolation was imposed on them to curtail the spread of the disease. Some recalled having adequate food, medicine, and communication when they quarantined at home, while others faced neglect, economic hardship, and emotional stress. An adult, male participant from Deraniyagala remembered his experience in a quarantine with satisfaction and gratitude. "I was placed in quarantine for 14 days and kept in isolation. During that time, I wasn't aware of exactly where or how they administered the vaccine, but I followed the necessary protocols. While I was isolated, the authorities provided all the essential food and medicine facilities, ensuring that my basic needs were met. Additionally, my family was also kept in isolation, though we were all kept informed and supported throughout the process. Despite the uncertainty and challenges of isolation, the necessary care was provided to us during our time in quarantine."

However, on the other hand, a middle-aged, male daily wage earner from the Deraniyagala plantation community recalled struggling through home-quarantine, without government support, amidst being cut off from his usual social connections. Inadequate sanitary facilities in plantation line-housing, and the lack of mental health support, highlighted how the imposition of quarantine on estate workers did not follow a comprehensive policy that appreciated their specific context. A middle-aged male participant from Deraniyagala said, "Since we live in row houses, where most of the homes are closely connected in a single line, our entire block was quarantined due to the Covid situation. Our family, along with others in the block, was isolated. This created a difficult situation, as no one could go to work or leave their homes during the quarantine period. Lack of support from both the government and the community made an already challenging time even harder, as we had to navigate isolation without the resources or the help we needed."

Indeed, many participants reported feeling dehumanised during home quarantine, recalling feelings of fear, anxiety over the lack of food and water, and the pain of social ostracism. A middle-aged male participant from the Jaffna public hearing remembered, "The Grama Niladari delivered food packets and left them outside the house. We felt dehumanised by this treatment; I have suffered significantly from the psychological impact." Another female participant from Deraniyagala recalled, "In the beginning, when quarantine programs were implemented in individual houses, we faced numerous inconveniences. We lacked proper sanitary facilities, which made it difficult to maintain hygiene and comfort during the isolation period. Moreover, the mental strain of being isolated at home, away from regular social interactions and support systems, was overwhelming. The lack of mental health resources and the constant uncertainty added to the stress, making the quarantine experience even more challenging."

Quarantine was imposed by force

Participants noted that there was heavy-handed enforcement of quarantine, where communities were treated as threats rather than citizens in need of support. A middle-aged male participant from the Ampara District commented, "The army handled the quarantines as if they were dealing with terrorists … it felt like being in prison." Sometimes quarantine was enforced without any medical basis, for instance, when a female participant from Jaffna recalled how she was forced to quarantine without any medical confirmation: "I attended church and was quarantined, despite not exhibiting any symptoms of Covid."

As Free-Trade-Zone workers observed in their focus group discussion, the quarantine processes within the Zones were chaotic and often run by the military without any training on empathy. As a FTZ worker organizer explained, all the residents of any boarding houses where Covid cases were found were quarantined in lump, with the army transporting large groups by bus—thereby increasing the risk of spreading the virus. Unlike health workers, the army lacked proper training, which affected their approach to quarantine activities. Family members were sent to different centres, causing confusion about each other's whereabouts. Their approach created fear and confusion among workers, exposed them to greater risks, and sowed mistrust within the wider population about them. Despite these shortcomings, according a healthcare worker participating in the Ampara hearing, military involvement was necessary for order. He observed, "We needed the military … without their involvement, it would have been impossible to enforce restrictions."

VACCINATION

Adverse events after vaccination remain unaddressed

There were diverging reflections on the impact of vaccination, showing a fragmented landscape of trust. While some participants were confident about the efficacy and safety of the vaccines, others were more sceptical or fearful, especially in the context of claims emerging within their communities as well as the broader public of various side effects, some of which even indicated possible fatalities. To many participants claiming adverse events after vaccination, their fears remain unaddressed to this day.

Not all participants were sceptical of the effects of the vaccines. As one adult male participant from the Anuradhapura district said, "I have no doubts about the Covid vaccine. I was a heart patient even before taking the vaccine. Therefore, I do not believe the story that vaccines cause heart disease." Another middle-aged female participant from the same district shared, "I thought about my children, thought about my health and took the vaccine because I was afraid of death." Indeed, the fact that the government had approved and promoted the vaccine buttressed the trust some participants placed in the vaccine. As a male participant from Deraniyagala shared, "I had all four vaccines and experienced no issues. The government wouldn't approve something dangerous." A middle-aged journalist from the Galle district said, "Vaccines prevented more deaths in Sri Lanka compared to countries that delayed their programs." Another middle-aged social worker from the Galle district said, "I was proud to get vaccinated as a social worker. It was my duty to protect myself and others." A retired [gender?] doctor from Galle district said, "As a doctor, I explain that the side effects (of the vaccines) are minor and far outweighed by the protection they offer."

Despite these voices reflecting confidence in vaccines, the hearings and discussions held by the Commission demonstrated the sufficiently widespread belief within the public that the Covid vaccinations caused various side effects. Many participants claimed to have suffered significant adverse effects after getting vaccinated, including infertility, allergies, kidney issues; new chronic illnesses such as asthma, joint pain, muscle weakness, fatigue; participants even mentioned neurological symptoms. These accounts indicated community rumours and lack of medical clarity, fuelling vaccine hesitancy and fear. At a minimum, they reflect a lack of communication and information about the vaccine, a lack of proper post-vaccination follow-up, and an urgent need for transparent reporting and investigation into adverse events.

As one male participant from the Anuradhapura District pointed out, "I have no faith in that vaccine. There are many opinions that it caused many side effects. Many medicines imported to Sri Lanka are substandard. Today the medical field has been used to make money. Therefore, there is no standard for these immunisation vaccines." Another female participant from

the Anuradhapura District confirmed her side effects from the vaccines, noting, "I had side effects after receiving the injections. Symptoms such as difficulty in breathing and pain in the hand appeared." A participant with disabilities from the Jaffna District said, "Swelling in the legs and arms increased, body weight rose … I could not walk very fast or travel very far." A female participant from the Kandy district recalled, "After receiving the second dose of the vaccine, my blood clotting started to happen faster. As a result, my blood pressure increased. One of my cousins also died due to a similar situation." A female estate worker from the Nuwara Eliya District said, "After the injection, there was pain in the knees and elbows. These issues only arose after the third dose. Moreover, many people developed heart conditions." A young mother in the Deraniyagala hearing shared, "I faint often now and have memory issues. I think it's due to the vaccine." A middle-aged male participant in Deraniyagala also claimed, "After receiving all three doses, I can't even lift 30 kg now. Before the vaccine, I could lift 80 kg." Another female participant in Deraniyagala said, "My relative died just a few days after getting the second vaccine. She had other conditions, but this raised huge concerns for us." Another young male participant in the Deraniyagala hearing said, "A healthy man who worked with rubber died after his first injection. We still wonder if the vaccine played a role." A female, Vedda participant from Mahiyangana recounted, "Most of us received the first dose of the vaccine. But only a few turned up for the second and third doses. The main reason for this was that after taking the first dose, many people had body pains and were unable to carry out their daily activities." Another female farmer from Mahiyangana said, "I received the first and second doses of the Covid vaccine. But I avoided the third and fourth doses, because most people who took them said taking those doses caused them severe pain."

Testimonies from public hearings and focus groups reveal coercion in the administration and promotion of Covid-19 vaccines, with many feeling their autonomy was diminished. One participant said, "The army handled the quarantines as if they were dealing with terrorists … it felt like being in prison." Strict enforcement measures made it hard for some, especially persons with disabilities and LGBTI+ individuals, to access medicines: "During the COVID-19 pandemic, we couldn't go out to get the medicines we needed. If we went out, the police would arrest us," shared one trans participant from Jaffna. Another added, "Regular consumption of hormone-related pills and their discontinuation can lead to an imbalance in the body. We were not able to get these pills. We experienced a lot of stress during that time."

Medical ethics suffered too, most notably with informed consent and transparency. "Doctors didn't explain the medications… we took medicines blindly…" said a middle-aged woman participating in the Ampara hearing. "Even the time gap for the second dose wasn't informed properly. It was unethical," reported another from Anuradhapura. A social activist from Galle noted, "The rapid rollout of the Covid vaccine, sometimes without sufficient public trials or long-term data on its effects, raised concerns and led to incidents where people reported adverse reactions. In some cases, legal cases were filed as a result of these reactions, reflecting public dissatisfaction and distrust." A FGD participant concluded, "There has been no comprehensive post-vaccine health research. That's a failure." Another participant said, "I have no faith in that vaccine. There are many opinions that it caused many side effects. Many medicines imported to Sri Lanka are substandard. Today the medical field has been used to make money. Therefore, there is no standard for these immunisation vaccines." Finally, "The media misused the pandemic to create fear… It made us distrust everything we heard," summarised one middle-aged male from Ampara. These voices illustrate the need for ethical standards, transparency, and respect for autonomy in public health.

Inadequate information on vaccines

The lack of informed consent and clear, accessible communication during the vaccination campaign underscored the urgent need for culturally respectful health interventions. Many communities, particularly marginalised groups, found themselves excluded from receiving information that was understandable and relevant to their realities. Health messages were often delivered in overly technical language, in languages not widely spoken by the affected communities, or without sufficient explanation of the risks and benefits, leading to a significant information gap. This failure to communicate transparently and inclusively contributed to growing public distrust—not just in the safety and efficacy of the vaccines themselves, but also in government authorities and Covid-19 protocols more broadly. As a result, resistance to public health measures intensified, misinformation and rumours proliferated, and the overall effectiveness of the vaccination drive was undermined. These shortcomings highlight the critical importance of establishing ethical standards in public health, including respect for autonomy, transparency, and engagement with the communities most impacted.

Based on public hearings and focus group discussions, there is a significant need for communication in health interventions to be clear, accessible, and culturally sensitive. Numerous communities reported feeling excluded due to information being presented in overly technical terms, in unsuitable languages, or lacking sufficient clarification regarding risks and benefits. This lack of transparency and effective engagement has contributed to mistrust towards vaccines, government authorities, and COVID-19 protocols, ultimately intensifying resistance to health measures as misinformation and rumours proliferated in the absence of accurate communication. Communication from health professionals was found to be inadequate; patients frequently received insufficient explanations about their treatments. As one middle-aged female participant from Ampara District stated, "Doctors did not explain the medications; we took medicines without understanding." Furthermore, some participants expressed concern over gaps in information regarding vaccination schedules. For example, a focus group discussion participant (PHI) from Anuradhapura District noted, "The interval between doses was not properly communicated. It was unethical."

A health worker Galle district who had involved in the vaccination rollout explained that,
"During the period when the Covid vaccine was being administered, I had the opportunity to work in the field of vaccination. During this time, numerous rumours and misinformation about the vaccine spread throughout society. One of the most significant misconceptions was the perception that the Pfizer vaccine was superior to other vaccines. This belief led to a situation where many people refused to accept vaccines other than Pfizer, even when they were offered alternatives."

People felt misled and unsupported by mainstream information sources. As a middle-aged man participating in the Ampara hearing said, "The media misused the pandemic to create fear … it made us distrust everything we heard."

Vaccines were coerced

Despite the rumours and fears about possible side effects from the vaccine, there was a marked lack of autonomy in deciding to receive them. Vaccination had become a mandatory precondition for enjoying other basic rights, by virtue of how many people were excluded, or felt threatened of exclusion, from hospitals, schools, workplaces, public transport, and other public facilities or services if they failed to show proof of vaccination. Thus, while the vaccination card ought to have been a confidential medical record, it instead became a de facto instrument of control and exclusion. As a female farmer from the Nuwara Eliya district explained, "We didn't take the vaccine because we wanted to, but because it was necessary for everything

else. We feared the consequences of not having it." Another male estate worker from the same district said, "If we didn't get vaccinated, they said we won't be allowed to board buses. They also said we couldn't go to the hospital without being vaccinated." Another participant recalled, "When my child got sick, the hospital wouldn't treat him until I showed proof of my vaccinations." Similarly, a female participant from the Anuradhapura district remembered, "When traveling to Mahiyangana, people on the bus were checked for vaccination cards. I didn't have one because I hadn't completed all doses." A male participant in Deraniyagala said, "We were told we couldn't leave the house or go to work unless we got vaccinated. It wasn't our choice." An adult male participant from Galle district said, "We were threatened with legal action and told we couldn't go outside if we didn't get vaccinated," while a female participant said, "PHIs pressured us. Those who didn't comply were stigmatised or denied services."

Although people were typically required to sign consent forms at vaccination centres, this process often underscored the sense of coercion experienced by many. As one female estate worker from Nuwara Eliya described, "I was asked to sign a card while receiving the vaccine. Willingly or unwillingly, I had to sign it. Even those who couldn't read were made to sign somehow." A male participant from the Mannar hearing observed, "The government didn't feel confident on the effectiveness of vaccines, hence required individuals to sign a consent form. This form stated that the government would not be responsible for any adverse effects caused by the vaccine, and they were asked to sign it before getting vaccinated. I felt that this process was done forcefully." Expressing his frustration, a middle-aged man from Batticaloa said, "We were not asked for permission when signing or given the vaccinations. It was forced. We were not given any explanation regarding the vaccine." Similarly, a male participant in the Kandy hearing highlighted the lack of information and autonomy among plantation workers: "The health sector had not given any prior information about this vaccine to the plantation workers community. They stated that everyone should get the vaccine. They also said that they will not be allowed to travel in public transport. So everyone signed and took the vaccine, albeit reluctantly."

Disposal of the Covid dead

Many participants recalled with pain the government's policies in relation to disposing of the Covid dead, including forced cremations, reflecting on how it denied them of the right to perform last rites in accordance with their religious beliefs. Many Muslims, in particular, expressed the pain and distress caused by the denial of the right to perform proper burial rituals, which forms a critical aspect of their faith. A female participant from Mannar said of her uncle's passing, "When my uncle passed away, they said he had Covid and cremated him. Before he died, he prayed to Allah, asking that his body be the last to be cremated due to the virus. He was a good, religious, and kind man." She expressed deep sorrow and heartbreak over the fact that they couldn't perform a proper burial ritual for their uncle, noting that cremation is considered a sin in Islam. An elderly male participant from the Mannar district said, "This is a human rights violation. The World Health Organisation said that burials are safe, yet we Muslims were forced to burn our dead." They maintain that the policy remains unforgettable and unbearable to them. As one participant in a focus group discussion with women, a widow of a person who died from Covid, said of her husband's forced cremation, "When my husband passed, we were not given any choice. The cremation happened so quickly … it feels like a constant wound that doesn't heal."

The sense of injustice and abandonment by authorities was a powerful and recurring emotion. The clash between pandemic policies and religious rights was particularly strong, leaving long-lasting scars on affected families and communities. As one retired, male Muslim participant in the Kandy district, shared, "I worked as a health assistant at the Kandy National Hospital for twenty-two years. During the Covid period, many injustices happened to

the Muslim people because of the cremation of the bodies of those who died due to Covid. Even the dead bodies of small children were cremated. Even scientists stated that burying corpses does not spread Covid. Later, the government apologised to the Muslim people for these things. But I suggest that they must give justice to the families of those cremated." In the Kandy hearing, a Sinhala female participant also voiced her support, saying, "We saw the injustice done to the Muslim people during that time. We also suggest that justice should be done so that such acts do not happen again."

However, quick disposal and cremation policies not only disregarded Muslim religious practices, but they also affected adherents of other major faiths, too. Members of the Christian and Hindu also commented on the denial of their funeral rituals. For example, as a female participant from the Jaffna district recalled, "A widow I know was unable to perform any rituals for her husband … the funeral rites could not be conducted according to Hindu traditions." As a male, Sinhala participant from the Ampara district pointed out, "It wasn't just Muslims… Hindus and Christians couldn't perform their last rites either."

Strikingly, the implementation of forced cremation and rapid disposal policies extended beyond confirmed Covid deaths. Testimonies reveal that individuals who died from unrelated illnesses, such as cancer or other medical conditions, were nonetheless classified as Covid deaths and subjected to the same restrictive rituals. This practice underscored the arbitrary and sweeping nature of the policy: families were denied the opportunity to conduct religious burial rites not only for those lost to Covid, but also for loved ones whose passing had no relation to the virus. The result was a deepening sense of injustice, as the denial of sacred last rites was experienced as a blanket imposition, disregarding both medical reality and the diverse religious obligations of grieving families.

During the pandemic, the policy of forced cremation extended beyond confirmed Covid deaths, deeply affecting families whose loved ones died of unrelated causes. In several distressing cases, individuals who had succumbed to illnesses such as cancer were nonetheless classified as Covid victims and cremated, regardless of actual cause of death. As one adult male Muslim participant from Ampara district shared, "A neighbour died of cancer, but the hospital declared it as Covid … and he was cremated against our religious beliefs." Similarly, another participant recounted, "My uncle got severely ill and admitted to the hospital, where he was vaccinated. Despite not having Covid, the hospital claimed he died from Covid and cremated him." These testimonies underscore the pain and injustice experienced by families who were denied the right to observe proper burial practices, even when Covid was not the true cause of death.

HEALTH SYSTEM FAILURES

Inequality in healthcare

The pandemic brought to light the longstanding disparities present in Sri Lankan public hospitals, particularly affecting the poor, ethnic minorities, and other marginalised groups. Many participants recounted experiences where social status or outward appearance appeared to influence the level of care and attentiveness received from hospital staff. As one disabled participant from Jaffna district observed, "Patients are treated based on the perceived value of their clothing… Those wearing sarongs receive less attention." This perspective was echoed by a female farming participant in the Vavuniya hearing, who explained, "When rich people come to the hospital, they receive good care. Poor people are treated harshly." Another female participant from Mannar District recalled, "Poor people are treated very badly in the hospital… nurses and doctors prioritised their own safety over protecting the patients." A female participant from Batticaloa said, "If we go to the hospital because of illness, the doctor looks at us as if we are untouchable. He inquiries from a distance and writes the prescription without properly examining us."

In addition to economic and social factors, the lack of culturally and linguistically appropriate care sometimes made it more challenging for vulnerable communities to navigate the healthcare system. Reports of discomfort and misunderstanding were shared by transgender persons, who described feeling neglected and subject to invasive questioning rather than receiving the medical attention they sought. An LGBTI+ participant from Jaffna district shared, "Even when we go to the hospital … they try to determine whether we are men or women," reflecting the need for greater sensitivity and respect for all individuals, especially those who do not conform to societal norms. These accounts suggest that inequities in healthcare delivery are complex and multifaceted and highlight the importance of fostering dignity and inclusivity for all.

For many communities across Sri Lanka, the onset of Covid did not mark the beginning of their challenges regarding health and dignity; rather, it emphasised difficulties that had been present for years, such as inadequate sanitation, food insecurity, substandard housing, and limited access to healthcare. The pandemic response proved in some cases to be limited in its impact, and at times, it heightened the burdens these communities faced. As one young woman from Kegalle District (Deraniyagala) described, "We live in line housing blocks, where the houses are arranged in terraced structures, with only 10 feet long rooms per person. The sanitation facilities are extremely limited, with only three or four toilets available per entire housing block. This lack of proper sanitation became even more problematic during the Covid period. Without adequate facilities for hygiene, every family faced significant health challenges."

Measures such as handwashing and social distancing, central to the public health response, proved difficult to implement where basic infrastructure was lacking. Overcrowded living quarters and insufficient sanitation underscored that communities were not starting from the same baseline. The pandemic added new risks to longstanding challenges, often without addressing their root causes. Similarly, gaps in healthcare infrastructure had existed before the crisis, but the pandemic made these issues more visible and, in some ways, more pressing. "We don't have a proper health centre to take care of children, which has been especially difficult during the Covid pandemic. The lack of a dedicated facility for children's healthcare has left us with limited options for seeking medical help for them during such a critical time," reflected a middle-aged woman, also from Kegalle District.

For communities long deprived of clean water, nutritious food, dignified homes, and nearby health clinics, the pandemic response was of limited usefulness. Guidance and protocols may have failed to fully consider local realities, leaving vulnerable populations struggling to meet even the most basic recommendations for protection against Covid. These experiences highlight the importance of addressing the underlying determinants of health so that future responses can better serve all communities, particularly those who have historically faced greater challenges.

Shortages in medicines, equipment, and facilities

During the Covid pandemic and subsequent economic crisis, Sri Lanka's public hospitals encountered difficulties in providing even basic medicines, such as paracetamol. Patients were frequently advised to purchase their medication from private pharmacies because hospitals were out of stock. This placed families in a position where they had to pay higher prices for essential drugs, with some noting that medicine costs changed rapidly and unpredictably. As a woman from the Mannar hearing said, "We had to buy medicine from outside at high prices. Prices changed from place to place, even hour to hour." A middle-aged woman from the Ampara hearing said, "The government hospitals were of no help. There were no medicines available … the prices were unbearable." As a farmer participating in the Mahiyanganaya/Girandurukotte discussion observed, "A person who used to spend 1,000

rupees now spends 5,000 on medicine. So, people buy only half the dose."

Shortages extended not only to medicines, but also to medical equipment and facilities. A participant in the Jaffna hearing recounted, "When we visit a government hospital, we are required to pay for eye lenses … surgeries are delayed due to a lack of medical facilities." A young woman from the Batticaloa hearing said, "After Covid, there is no medicine in the general hospital … they even asked my sister-in-law to buy a prenatal test kit outside." A middle-aged, female community worker in the Colombo hearing shared, "We pay separately for tests, injections, and have to buy all medicines from pharmacies." As a male social activist participating in a Kandy hearing pointed out, "Hantana Estate has two hospitals for seven divisions … we clean the hospitals ourselves, but essential medicines are unavailable."

Those with chronic conditions are particularly affected by shortages. At the Kegalle hearing held in Deraniyagala, a participant explained, "I am a cancer patient, and I rely on medication every month for my treatment. However, during the Covid pandemic, I faced immense hardship as I could not obtain the necessary medicines for three months. This shortage of medication caused significant damage to my physical health, and I was unable to go out to find the required treatments." Chronic kidney patients were also affected by the shortages. As a participant in the Mahiyanganaya/ Girandurukotte discussion pointed out, "We have to spend a lot of money to buy kidney medicine from private pharmacies." While having to spend upwards of Rs. 25,000 per month on medication, the shortages they experience are not only in terms of medical supplies. "We have around 2,500 kidney patients in this area but not one specialist," said a woman participating at the same discussion. Another male kidney patient observed, "During Dr. X's tenure, even patients from Ampara came to Girandurukotte Hospital. But, after he left, no kidney specialist has been appointed."

Encroachment by privatised health services

In the context of these shortages, participants recounted being asked by government doctors to attend their private clinics, highlighting how the same medical officers would give them different standards of care in the different settings. One young woman participating in a hearing in Mannar shared, "Doctors treated us badly in the government hospital, but kindly in their private clinics." Many participants recounted being redirected to private practices or specific pharmacies—sometimes without a proper diagnosis. As a male participant from Kandy district recounted, "The doctor told me to come to his private clinic without even diagnosing me." Such cases raise troubling concerns over kickbacks and corruption, exposing the ethical dilemmas at the heart of dual practice. "All doctors send their patients to private centres. People don't have the money for that," shared a young mother from Colombo District, highlighting the economic strain this model imposes on families.

The unregulated dual practice model leads to mounting out-of-pocket expenses and erodes trust in doctors and the healthcare system, and some are forced to make financial sacrifices—sometimes going into debt—to access care from the private sector. Essential medications and procedures in public hospitals are often "unavailable" or subject to long delays, while the same services become accessible in private clinics.

Ultimately, the presence of private clinics manned by public doctors transforms healthcare from a public good into a commodity, deepening social divisions and leaving vulnerable groups behind. Public trust is eroded when patients see quality care in public hospitals intentionally undermined to promote private business, leading to cynicism, resentment, and further disengagement from public services. As one adult male participant from Kandy district expressed, "We want essential medicines at a price we can afford,"

capturing the urgent need for accessible and fairly priced healthcare at the heart of these concerns.

Differential standard of care for non-Covid patients

With hospitals focused on controlling the spread of the virus, some patients with non-Covid medical conditions felt that the quality and timeliness of their care was affected by the prioritisation of pandemic protocols. For individuals seeking urgent medical attention, new procedures sometimes led to delays and additional stress. As recounted by a participant from Mannar District, "My daughter fainted with a severe head injury, but hospital staff delayed treatment until a PCR test was done. It was torture." Such incidents illustrate how emergency care—usually intended to be prompt—was influenced by containment priorities.

Administrative hurdles also impacted those managing chronic health conditions. One participant described her experience with a heart problem, noting repeated requests for her to return for a required medical report and the need to be vaccinated against Covid before receiving treatment. This example shows how non-Covid health needs were sometimes deferred until certain protocols had been met. Another adult participant from Vavuniya District said, "My son started vomiting suddenly, but treatment was delayed due to mandatory testing." In this instance, Covid screening took precedence over addressing acute symptoms, highlighting the challenges faced by vulnerable patients. Delays extended to routine hospital visits, with new admission procedures causing longer wait times. As one middle-aged woman from Vavuniya District explained, "When we went to the hospital, we were not allowed in immediately. We had to wait outside while they did the initial Covid test."

These experiences offer insight into the complexities of pandemic response within healthcare systems. While the emphasis on protocols was essential for infection control, it sometimes resulted in reduced access, delays, and a sense of uncertainty for patients with other medical concerns. The emotional impact was compounded by frustration and apprehension, as community members worked to navigate a system adapting to an unprecedented crisis. As Sri Lanka moves forward, reflecting on these experiences may help ensure that future responses balance the need for public health measures with the ongoing imperative to treat all patients with urgency, dignity, and empathy.

Negligence and diagnostic errors

Negligence and careless mistakes, often resulting from inadequate standards in care and service, were recurring themes in participants' accounts. Several individuals described critical lapses in medical professionalism, such as mislabelling of blood samples and errors that went unacknowledged. As one middle-aged female community worker from Colombo District shared, "Colombo General Hospital mixed my blood sample with someone else's. I didn't know who to complain to." Another echoed the frustration, saying, "I waited for hours [at hospital], only to find someone else was called for my number."

Systemic failures in patient tracking, grievance redress, and basic procedural care contributed to these distressing experiences. A young mother from Ampara District recounted, "My child got dengue… But when we took the prescription… the pharmacist said the medicine was meant for diabetic patients." A young woman participating in the Mahiyanganaya/ Girandurukotte hearing voiced that, "Some doctors don't even test us properly; they just prescribe medicine." These remarks highlight a troubling pattern of oversight and indifference, leaving patients vulnerable and uncertain about the quality of their care.

Need for effective grievance redressal

Participants highlighted the need for a specific health service complaints mechanism in the

context of the negligence, diagnostic errors, and systemic failures they described in the hearings and discussions. Corruption and institutional distrust were openly discussed at public hearings. Many criticised the influence of drug mafias and those with political connections who received commissions at the expense of fairness. As one young female participant from Badulla and Monaragala Districts said, "The main factor behind drug shortages is the medical mafia, and the government didn't act." An adult male participant from the same districts added, "Ministers get commissions; nobody thought about poor villagers." These statements reveal deep public disillusionment with health governance.

Even when a complaints system exists, many are reluctant to use it. As a male participant (FGD – CKDu patients) explained, "Even if there is a complaint system, people won't use it. We still have to return to the same doctors." The fear of reprisal, lack of awareness, and cultural barriers are significant obstacles to effective redress. To truly empower patients and restore trust, a complaints mechanism must make reporting grievances safe, accessible, and confidential, ensuring every complaint is addressed fairly and transparently.

GENDERED IMPACTS

Domestic violence

The hearings highlighted a significant increase in domestic violence against women and children during the pandemic. Female participants said that the lockdown measures led to heightened tensions within households, particularly as men who typically worked outside the home were confined indoors for extended periods, resulting in various forms of abuse. In some narratives, the violence was precipitated by substance abuse, as some men found avenues to brew illicit alcohol and sell drugs despite the lockdowns. As an adult female participant shared, "There were many illegal activities in the village during Covid, including drug trafficking and use, as well as homemade alcohol (Kasippu). These activities caused many problems in families, leading to domestic violence and numerous health issues." A middle-aged female participant from the Ampara district recalled how, "Samurdhi money … was spent on alcohol … This led to severe violence in the home." A female participant in Batticaloa working with a women's organisation said, "Many women reported that when men were at home without work, they fled to the jungles and hid."

Women's health neglected

While the Covid period saw an increase in the care work falling on women, with some having to care for entire households without any support or even basic necessities like baby formula, female participants reported the lack of prioritisation for women's health, the unavailability of sanitary products, amidst increased domestic violence due to financial strains and alcohol abuse. On period poverty, a young female participant from the Ampara district said, "We couldn't even get basic sanitary products … many of us secretly stitched fabric pads."

Mistreatment of women in the context of obstetric care was also discussed. Several female participants described inhumane treatment of pregnant women. For example, a participant in the Mannar district said, "They hit some women on the stomach for screaming during labour," and another claimed that, "Infant deaths occurred due to negligence by doctors and nurses. Yet they blamed the mothers."

Their stories reflected a deeply patriarchal and punitive healthcare culture, where pregnant women are punished rather than cared for and a profound lack of respect, empathy, and safety in maternal care, which is a core component of the right to health.

IMPACT ON MARGINALISED GROUPS

Persons with disabilities (PWD) reported experiencing mistreatment or neglect. For example, a caregiver from Mannar district described an incident in which incorrect symptoms were recorded by nurses, resulting in misdiagnosis. As she explained, "The nurse wrote down the wrong symptoms, so the doctor gave the wrong treatment." Language barriers have also contributed to errors; a female participant from Mannar district noted that a Sinhala doctor misdiagnosed several patients due to not understanding Tamil, stating, "Because the doctor did not understand Tamil, he made mistakes in diagnosing us."

The pandemic heightened existing difficulties faced by the LGBTI+ community, including reports of sexual harassment, police violence, and healthcare discrimination. Economic hardship led some individuals to engage in sex work as a means of survival. A lesbian participant from Jaffna district stated, "We had no choice but to do this because there were no jobs," while another transwoman participant noted, "At the hospital, staff asked questions about my personal life that had nothing to do with my health." Additionally, a blind female participant observed, "They say facilities for the disabled are available at government hospitals, but often they are not working." Other participants described being treated differently based on appearance or occupation, with one noting, "If you look poor or like a labourer, they ignore you."

Further accounts included medical staff maintaining physical distance, providing minimal interaction, and favouring certain patients. One person shared, "The nurses only talk nicely to people they know. If you don't have connections, you wait much longer." Some reported that nurses prioritised acquaintances, leading to longer wait times for others. There were also observations regarding perceived differences in treatment of Tamil-speaking or plantation worker patients compared to others, as highlighted by a participant: "Plantation workers and Tamil speakers are not treated the same as others."

PWDs identified additional barriers such as inaccessible facilities and a lack of sign language or translation services in hospitals. Many participants expressed concerns about negligence among healthcare workers and alleged preferential treatment for those who were educated or had connections. One said, "If you are educated or know someone in the hospital, you get better treatment," while another commented, "Staff cannot communicate with deaf patients because there is no interpreter." Language barriers were again highlighted as impacting access to healthcare.

These accounts suggest challenges in the health system related to equitable and culturally competent care, underscoring the importance of training healthcare professionals to fulfil their responsibilities towards all patients.

Workers in the Free Trade Zones (FTZs) represent a distinctive demographic, as many are not originally from the areas in which they work. They reside in boarding houses, and their registered places of residence and voting stations are often located elsewhere. During the lockdowns, these workers found themselves confined to tightly packed accommodations, unable to travel due to restrictions. As the convener of the Shramabhimani Centre explained, "workers were trapped in overcrowded boarding houses during lockdowns due to lack of transport."

Despite the fact that companies reportedly saw "120% profits" during this period, salaries for workers did not increase, nor were adequate health facilities provided. The situation became even more trying when a single worker tested positive for COVID-19; in such cases, entire boarding houses were quarantined, and allowance cuts were imposed even on healthy individuals. The lack of consistent implementation of health measures compounded the difficulties faced by these workers.

Apparently, only a minority of factories provided alternative accommodation and health support for infected workers. The government's efforts in vaccination were more positively received within the FTZs, with some collaboration between factories and health officials. However, persistent health risks continued to affect the workforce. Food poisoning remained common, and "only two Public Health Inspectors (PHIs) serve a population of nearly 50,000 workers." Medicare services were limited to those enrolled, forcing others to purchase medicines out of pocket, and no nearby hospital was available for immediate or serious cases.

The pandemic not only exacerbated physical health issues but also had a profound impact on mental well-being. Isolation, financial stress, and the lack of institutional support triggered widespread mental health concerns, as highlighted in multiple hearings and discussions. Workers faced these challenges with resilience, but the consequences of systemic neglect and the absence of comprehensive care left deep and lasting scars.

MENTAL HEALTH DURING THE PANDEMIC

Mental health issues caused and triggered by the pandemic response was another major issue discussed in the hearings and discussions. As participants highlighted, isolation, financial stress, and the absence of institutional support triggered mental health issues.
As one male participant from the Katunayake Free Trade Zone said, "There were no steps taken by the government for mental health. Families struggled with rent and food. Conflicts arose." He pointed out how some civil society organisations stepped in to provide mental health counselling with the support of doctors, a service otherwise missing from the public response.

Free Trade Zone workers crowded into cramped boarding houses and isolated from their families were particularly vulnerable and spoke of these conditions outing them in a "mentally weak state." The government's decision to cremate everyone, irrespective of whether or not they had Covid and without consideration of their faith, caused great mental distress to people – especially the Muslim community. They spoke of carrying emotional burdens of guilt and trauma. Those with pre-existing medical conditions feared that their conditions would worsen without treatment and this mental anxiety compounded their physical suffering.
Informal workers and mobility – dependent workers were tormented by their loss of livelihoods and income, causing them anxiety and mental distress. On-line learning was inadequate and poor students who could not access the technology were frustrated and became depressed as they were falling behind. Participants from Mannar noted that the long periods in lockdown made the men who used to work outside the home feel trapped and the incidents of domestic violence and abuse of children rose. The inability to interact socially and participate in religious and cultural festivals were also a cause of depression for many and participants from Nuwara Eliya who loved in cramped line houses observed that those who did get Covid were stigmatised and this caused anxiety to them.

IMPACT ON LIVELIHOODS

Lockdowns and curfews devastated livelihoods, especially in the informal sector. Self-employed workers and marginalised groups lost incomes and were left with no consistent support. Economic vulnerabilities were intensified drastically by the pandemic and the subsequent economic crisis, creating severe impacts on income, debt, and survival. As a young, female participant at the Jaffna hearing said, "I typically sell eggs, milk, and vegetables … during lockdown, none of my neighbours purchased my products." A middle-aged male participant from the Ampara district said, "We had started a small business … when lockdown began, our business collapsed … now, we are drowning in debt." People remain caught in debt traps as the promised relief measures like loan moratoriums often backfired causing compounded debt. For

example, a middle-aged female participant explained, "The government announced a moratorium on loans … over time, the interest on our loans doubled and tripled."

Though the government announced relief programmes for those affected, a recurring theme was unequal distribution and the neglect of marginalised groups within those programmes. Relief mechanisms failed many, while, in some instances, grassroots solidarity often filled the gap. As a female social from in the Batticaloa district said, "I delivered relief items to numerous homes on my bike. However, when I was quarantined, there was no one available to even buy formula for my child."

This imbalance underscored how systemic failures were partly mitigated by community care and informal networks. Thus, despite systemic breakdowns, local communities displayed solidarity, adaptability, and creative survival strategies, drawn from their cultural heritages. There was an increased use of traditional medicine and local herbal remedies played a central role in healthcare. An adult male participant from the Ampara district said, "We turned to herbal remedies… jasmine leaf tea became our go-to medicine." Community care networks were galvanised and local communities ensured vulnerable people, especially children, were not abandoned.

RECOMMENDATIONS

While the objectives of the study were to record the experiences of citizens during the pandemic the findings went beyond these experiences and pointed to broader and deeper structural failures in the healthcare system to be addressed. The aim of the inquiry is to highlight the structural and other failures, create awareness with a view to improve the public health system in Sri Lanka which is undoubtedly as asset to be preserved and enhanced.

Multidisciplinary approach to strengthening healthcare:

- Emphasis on integrating sociology, psychology, and law disciplines into healthcare, thereby creating a holistic understanding of community health and patient rights.

- Local/traditional medical systems should be further developed, and government support should be given for it.

- Invest in wellness:
    - Food safety should be researched, and people should be educated on nutrition and chemicals used in food production should be limited.

    - Restore distribution of nutritional food for pregnant women which was halted due to the economic crisis.

- Health educational reforms: There was consensus on the need for programs to build health rights awareness, empower individuals to challenge the violations of their health rights and low-cost health alternatives to invest in wellness.

- Provide health related communications in all the languages the ensure that everyone understands

- Counter mis information about the vaccine and alternative treatments

- Community empowerment: There is a need to strengthen civil society institutions and grassroots organisations to advocate for sustainable health advocacy.

- Conduct more health and health rights awareness programs like this in rural areas.

- Trainings: Train the health sector (doctors, nurses, attendants and health administration) to:
    - Understand that patients have a RIGHT to Health,
    - That they, the health sector workers are health service providers obligated to provide professional and compassionate care.
    - Train the health sector in empathetic communication with patients irrespective of their social strata.
    - Minimise the gap between doctors and patients and ensure that every patient receives proper and respectful treatment.
    - Secure ethical consent from patients prior to treatments.
    - Patients should receive clear explanations of their treatment and medications in a language and in a way that they can understand.
- Complaint mechanisms: Establish mechanisms to receive complaints from citizens relating to the health injustices that occur to them. Strong groups of citizens should be formed and empowered to speak out in the face of injustices that are happening to them.
    - Publicise the 1907 hotline widely and encourage people to complain about the violations of patients' rights. Consider printing stickers and notices and place them in public places including hospitals, dispensaries, pharmacies and other public offices.
    - Establish an institution (like the police) to receive complaints about malpractices of hospital staff including the doctors.
    - Copies of the complaints against the injustices in the hospitals should be sent to all authorities.

Hospital reforms

- Hospital Development Committees should be formed at every hospital, and they should function actively with the participation of citizens. A broader awareness should be made about it through local hospitals and media.
- A proper system should be established to inform the people about the decisions taken by the government in relation to health sector.
- Reduce the number of doctors going abroad and prepare a mechanism to retain them in this country.
- Steps should be taken to improve rural and regional hospitals.
- Government doctors should be banned from working in private hospitals and private channel centres.
- Government to recognise and address that unethical practices exist among some doctors and address this.
- Prioritise the supply of quality medicines in the government hospitals
- Invest insanitation reforms and recognise it is a part of the health sector

Government's post-vaccine responsibilities:

- The government should conduct a proper, scientific investigation on the side effects of vaccines and people should make the public aware of it immediately

- Compensation and reparations for injustice: Justice, compensation for the victims and punishment for those who are responsible of making decisions on forced cremation.

- Government to evaluate the protocols including communications with the public during the pandemic and establish fresh protocols to address with future health emergencies. This includes:

    - Awareness that health emergencies have cascading, catastrophic impacts on families, their access to livelihoods, their children's access to education and the state support must be cognisant of this.

    - Reviewing the communications strategies used and protocols for securing patient's consent

    - Assessing the deployment of the military

    - Delivery of social support during lockdowns

    - Obligation to minimise livelihood hardships

    - Framing gendered responses in future health emergencies

    - Prioritising protocols for disability access

    - Addressing the concerns of sexual minorities and the challenges including discrimination they face

    - Prioritising hospital access and care for maternal and paediatric emergencies

    - Ensuring that hospitals have staff trained in all the official languages and notices are printed in all the languages

    - Respecting that patients have emotional and phycological needs that must also be addressed during health emergencies.

    - Training the 1990 emergency ambulance service to respond to accidents promptly. Staff working in this service should be proficient in Sinhala, Tamil, and English.

Looking beyond the pandemic: Improving long-term healthcare

- Create a network of low-cost alternatives to provide basic healthcare

- Create inter-agency health committees (Ministries of Health and Labour, and CSOs) to establish factory-based health education and monitoring systems and mechanisms to protect and claim health rights (especially in the FTZs)

- The government must re-build trust in the healthcare system and commit to preserving free medical care and free education even though the government has made agreements with the IMF to do the contrary. The move towards privatisation should be halted because privatising healthcare and education will severely impact low-income individuals and violated the right to health.

ANNEXURE 1: COMMISSIONER'S PROFILES

Dr. Vinya S. Ariyaratne, the Lead Commissioner, is a renowned public health expert and community medicine specialist with over 30 years of experience in health equity, humanitarian response, and grassroots development. He currently serves as Honorary President of the Sarvodaya Shramadana Movement, Sri Lanka's largest civil society organization.

He holds an MD and MSc in Community Medicine from the University of Colombo and an MPH from Johns Hopkins University, USA. A board-certified community physician and respected academic, Dr Ariyaratne also co-chairs the UN Health Cluster in Sri Lanka and advises the World Health Organization on COVID-19 and health systems strengthening.

Honored with the Outstanding Social Entrepreneurship Award by the Schwab Foundation and a Doctor of Civil Law (honoris causa) from Durham University, he brings ethical leadership and deep public health expertise to the Commission's work on pandemic justice and right to health.

Dr. Kaushalya Ariyarathne obtained her Law degree from the Faculty of Law, University of Colombo, Sri Lanka, and Masters in Human Rights and Justice from Keele University, United Kingdom. She completed her doctoral studies at the Faculty of Graduate Studies, University of Colombo. Her research areas include women in politics, human rights, gender, queer and subaltern studies. She is affiliated to the Centre for the Study of Human Rights, Faculty of Law, University of Colombo as the Sri Lankan Academic Coordinator and a lecturer of the Asia Pacific Masters Degree in Human Rights and Democratisation. Dr. Ariyarathne is also a visiting lecturer at the Faculty of Graduate Studies and Faculty of Arts, University of Colombo and Department of Social Sciences, Open University of Sri Lanka. She has also been actively engaged in research on political activism of women, and LGBTIQ rights in Sri Lanka since 2010 and was elected to Parliament in 2024.

Hasanah Cegu is an Attorney-at-Law, feminist activist, translator, and independent researcher with over 18 years of experience in law, gender justice, and community empowerment in Sri Lanka. She holds an LL.M from the University of Colombo, specializing in Women's and Children's Rights and International Humanitarian Law.

Her focus is on legal reform, reproductive rights, and Muslim personal law, including research on child marriage, abortion access, and the Quazi court system. Hasanah is a co-founder of Muslim Personal Law Reform Action Group (MPLRAG) and the Priyam Collective, and actively promotes queer and trans rights, and decolonised feminist approaches to justice.
In her advocacy, she ensures that the voices of women, queer persons, and Muslim communities are included to shape Sri Lanka's path toward inclusive and equitable health rights.

Sumudu Chamara is a journalist, content writer, and project consultant. He started his career as a project management professional. During the past decade, he worked with several leading civil society organizations and various stakeholders at local and international levels. On garnering hands-on experience in human rights-related community-based activities, and writing, he entered the media field to work with prominent digital and print media institutions. He writes about social issues, health, politics, law, policies, and human rights, and human-interest stories are one of his fortes. He won several awards in recognition of his journalistic work pertaining to healthcare and on social issues. He writes feature articles and he works as an independent project consultant.

Prof. Piyanjali de Zoysa is a Senior Professor at the Department of Psychiatry, Faculty of Medicine, University of Colombo. She is a Clinical Psychologist by profession with a Bachelor's (Hon) degree in Psychology, a Master's degree in Applied (Clinical) Psychology, and a Ph.D. Her Ph.D. was on child-directed violence. She co-founded an MPhil degree in Clinical Psychology at the University of Colombo, which is the first training program in professional clinical psychology in the country. She was the founder president of the Sri Lanka Psychological Association. Further, she co-founded and hosts the weekly television program on mental health on Rupavahini, "Winadi 9ya," which is a psychology-psychiatry dialogue. She has held several key positions in national-level organizations, including the National Child

Protection Authority, the National Steering Committee on Child Rights, and the National Mental Health Advisory Council. Her research interests include humanness, culturally appropriate psychological interventions, child maltreatment, and violence.

Prof. Chandani Liyanage is a sociologist and works on health issues, traditional and complementary medical systems, disability, contemporary social issues, and social protection policies. She obtained her BA and MA degrees from University of Colombo, Sri Lanka, and her PhD from Delhi University, India (2007). She was Head, Department of Sociology (2014 -2017) and is a professor at the Department of Sociology, University of Colombo (since August 2019). She was the founding director of the Center for Disability Research, Education and Practice (CEDREP) (2014 - 2018); Chairperson of the Ethics Review Committee for Social Sciences and Humanities (ERCSSH), Faculty of Arts, University of Colombo (2015-2021) and a member of the Ethics Review Committees of the Faculty of Medicine and Institute of Indigenous Medicine, University of Colombo (2015 – 2022).
She received a Fulbright Advanced Research & Lecturing Award in 2011/2012 and was affiliated to the Center for South Asian Studies at Syracuse University. She was Visiting Faculty at Ljubljana University, Slovenia (2013) and she received a fellowship for Professionals-on Demand for Disability Rights in USA (2015). She has published in reputed journals and contributed to publications including 'Socio-cultural construction of disability', 'A Paradigm for Well-Being: Social Construction of Health' and 'Social epidemiology of Chronic Kidney Disease of uncertain etiology in Sri Lanka. She is currently involved in collaborative research on 'Empowering Cutaneous Leishmaniasis patients (ECLIPSE).

Ms. Kosalai Mathan is a legal academic and human rights advocate, currently serving as Head of the Department of Law, University of Jaffna. With over 15 years of experience in legal education, constitutional law and community-based research, she brings a strong justice and governance perspective to the Commission's work. She holds an M.Phil from the University of Colombo and qualified as an Attorney-at-Law (First Class). She was former President of the University of Jaffna Teachers Association and Convener of the Jaffna Law Conference (2024). She has worked with the ILO, Centre for Poverty Analysis, and the National Committee on Women, contributing to gender-sensitive governance and post-war development. She brings deep insights from the North, advocating for structural reforms to ensure justice in Sri Lanka's post-pandemic recovery.
Dr. Gameela Samarasinghe is a clinical psychologist and academic with over 30 years of experience in psychosocial wellbeing, trauma recovery, and transitional justice. Currently she is Associate Professor of Psychology at the University of Colombo and the founding Director of CEDREP (Centre for Disability Research, Education and Practice).

She holds a PhD in Psychology from Université de Bretagne Occidentale, France, and has authored widely on mental health, political violence, and community healing. She has served as a technical expert for UNFPA, WHO, IOM, and Columbia University, and advises national institutions on psychosocial and child protection issues.

Sivagnanam Prabaharan is a development practitioner, social researcher, and journalist with over 20 years of experience in advocating for human rights, labour right, and community development particularly among Up-Country Tamil communities. He has both supported and led multiple civil society projects with organizations such as the Institute of Social Development, National Peace Council, and Monaragala Peoples' Development Foundation. He holds an MBA from the Postgraduate Institute of Management, University of Sri Jayewardenepura, and a BBA in Human Resource Management from the University of Colombo. His academic and professional work focuses on inclusive governance, environmental justice, and the socio-economic rights of marginalized groups.

Krishna Velupillai is a human rights, peacebuilding and development practitioner with over 10 years of dynamic experience within the development sector in Sri Lanka. She has extensive experience working with UN agencies in Sri Lanka, including as a Technical Specialist at OHCHR and UNDP. Currently, Krishna serves as a Director at Strategic Inspirations Pvt. Ltd. She also works as a freelance consultant on human rights and development.

ANNEXURE 2: PARTNER ORGANISATIONS AND NETWORKS

Districts	Partner Organizations and Networks
Jaffna	Karuvi Centre for Social Resource Differently Abled, Voice for Equality
Vavuniya	Mother Theresa Women's Organizations
Mannar	NAFSO
Batticaloa	SURIYA Womens Foundation
Ampara	Human Elevation organizations (HEO), Affected Women Forum (AWF), Eastern Diriya Women's Development Foundation
Kandy	WE-FOR-RIGHT
Nuwara Eliya	Organization for Social Development, Bogawanthalawa Women's Organization
Monaragala	Wellassa Organization of Persons with Disabilities, Vikalpani
Anuradhapura	Janajaya Health Service Union
Kurunegala (Madagalla)	PARL(People's Alliance For Rights to Land)
Galle	Udugama Human Rights Team
Katunayake	Dabindu Collectives
Deraniyagala (Kegalle District)	WeEffect networks
Colombo	People's Parliament networks

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