Original Research Article

Adolescent and Youth Sexual and Reproductive Health in Sri Lanka: Are policies and strategies geared to address issues?

ABSTRACT

Aims: Adolescents and youth belong to high-risk groups for sexual and reproductive issues. The aim of this investigation is to critically evaluate whether the sexual and productive health issues are addressed in adolescent and youth policies and strategies in Sri Lanka.

Study design: Two distinct methods were used. Desk review to assess the coverage of sexual and reproductive health (SRH) issues are addressed in adolescent and youth policies and strategies in Sri Lanka was followed by 3 focus group discussions (FGDs) with ~~participation of~~ youths and 8 key informant interviews (KII) on SRH policy issues related to sexual and reproductive health of youth.

Place and Duration of Study: Both methods were conducted between June 2021 to December 2021. Youth were selected from District of Colombo for FGDs. KIIs were conducted with youth SRH experts in government, private, universities and non-governmental organizations.

Methodology: Triangulation of data from FGDs, KIIs and desk review was conducted. Thematic content and narrative methods were used for analysis of data.

Results: Adequacy of SRH coverage, issues and challenges was summarized using key six domains of SRH as mentioned by World Health Organization, namely overall focus on SRH, comprehensive SRH Education, contraception counselling & provision, safe abortion care, sexually transmitted infections (STIs) and HIV prevention care, and violence against women and girls- prevention, support and care. All key stakeholders in education and health sector unanimously agreed that comprehensive sexual education should be implemented in the country. However, there is general disagreement on the grade (or age) of inclusion of contraception of CSE; Level of skills and competencies of the teachers assigned to teach SRH and; Learning aids for students on SRH. The only policy/ strategic plan which covers the SRH aspects of youth adequately was the National Strategic Plan- Adolescent and Youth Health (2018-2025) by the Family Health Bureau. Similarly, lack of priority for SRH aspects of Youth was evident in youth policies and strategic plans formulated by non-health governmental organizations.

Conclusion: Overall findings highlight the non-priority for SRH aspects in youth policies and strategic plans in Sri Lanka. Coordinated effort of all key stakeholders is needed to improve

Comment [P1]: Throughout the article, youth has been used alongside adolescents inconsistenty. Technically, 'youth' includes both adolescents and young adults. Authors can stuck to just 'youth' too to have a broader age group.

the SRH representation in youth policies and strategies in Sri Lanka.

Keywords: Sexual and reproductive health, Policies, Strategies, Youth, Adolescents, Sri Lanka

1. INTRODUCTION

During youth, independence and autonomy from family increases and peer relations become more influential in decision making. Despite the increased independence from the immediate family, family and parents or caregivers still have a great impact on health of youth. Family positively influences the youth by the provision of protection from harmful factors such as drugs, alcohol, and other high-risk behaviours whereas unfavourable family environment which include unhealthy relationship between the parents, child marriage practices could negatively influence the youth. In addition, immediate family is the key determinant in provision of education to the youth and access to quality health care. New technology and social media provide opportunities for better access to information and services, but can also reinforce vulnerabilities, including exposing youth to bullying, sexual abuse, depression, or mental health conditions. Youth are also vulnerable to the commercial environment which include food, tobacco, and alcohol marketing. Thus, youth including their sexual and reproductive health needs special attention which should begin at policy level [1].

The World Health Organization (WHO) has~~ve~~ highlighted key areas in sexual and reproductive health to be included in youth sexual and reproductive health policies, strategies, and activities. They are comprehensive sexuality education (CSE) provision; contraception counselling & provision; antenatal, intrapartum and postnatal care; safe abortion care; sexually transmitted infections (STIs) prevention and care; human immunodeficiency virus (HIV) prevention and care; violence against women and girls prevention, support and care; harmful traditional practices prevention [2].

"Comprehensive S~~s~~exuality E~~e~~ducation (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and adolescents/ youth with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives" [2].

Comment [P2]: Matches the source exactly at http://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf?ua=1

Global Accelerated Action for the Health of Adolescents – (AA-HA) provides policymakers with guidance on how to prioritize, plan, implement, monitor and evaluate adolescent and youth health programmes [1].

Comment [P3]: Consider including this sentence in one of the paragraphs to have consistent paragraph length.

In Sri Lanka, Ministry of Health in partnership with World Health Organization in the year 2008, conducted comprehensive human rights-based assessment of its legal and policy environment for youth SRH. This was the most recent comprehensive review conducted in Sri Lanka and included both public health and legal experts. The review team analysed the extent of harmonization of domestic law with international human rights standards and principles in SRH which includes special attention to marginalized and vulnerable sections of the population. They include the informed consent of the youth/ adolescent, privacy, and confidentiality. The review highlighted discrepancies between adequate laws and policies and inadequate implementation as well as the enforcement of the laws. In addition, it identified the stakeholders responsible for addressing these identified gaps and barriers. In

UNDER PEER REVIEW

addition, this review identified the inadequacy in legal protection and policy recognition for the SRH needs of the marginalized and vulnerable youth like in estate sector and in families in poverty. The review team also highlighted discrimination and inadequate legal protection against such situations for pregnant teenagers and youth living with HIV/AIDS in places like education settings. Incidences like expulsion from schools were reported due to the discrimination faced by such youth in the country. In addition, the review team described the gaps between the realities of youth sexuality and confusing laws and policies, and poor law enforcement against sexual violence [3].

Comment [P4]: Consider rewording as ‘in addition’ used in the previous sentence as well

In a report of Regional Programme Managers’ meeting by World Health Organization-SEARO region identified key areas to be addressed by the member countries including Sri Lanka to improve the SRH of youth. They include acceleration of the evidence-based advocacy to ensure political commitment to bring youth health into the mainstream of policy-planning with an equity approach. Further, the reported stressed the need to invest in adolescent and youth health as a priority agenda in the national policy to be visible amongst the different national priority health programmes. In addition, the report highlighted the importance of incorporating the monitoring and evaluation systems as an integral part of the implementation plans of SRH of youth with agreed indicators consistent with national standards. The WHO reported stressed the need to ensure youth participation in programming (planning, implementation, and monitoring), their mobilization, optimum utilization and sustainability complemented by youth–adult partnerships based on innovations. And the importance of encouraging innovations in SRH service provision for youth. Further, specifically for Sri Lanka, the report highlighted the need in reviving the multi-sectorial steering committee on adolescent health; Reviewing the adolescent and youth health programme at different levels (national, district); Mainstreaming of adolescent and youth friendly health services within Primary health care settings with new innovative packages [4].

In Sri Lanka, visualized outlook for growth of youth population based on population projections show that from 2017 the size of the 15-29 youth population would start to increase numerically and by 2022 it would reach 4.8 million with a significant growth of youth population could be observed by 2032 with 5.2 million [5-6]. The field survey carried out by PI and the team in 2019 with the support of ChildFund among the never married youth revealed that 10 and 7 per cent of males in 15-19 and 20-24 age groups respectively stated that SRH were not at all discussed in school environment. The same study further revealed that 40 per cent reported that internet via mobile phone as the most popular source to search SRH information. Above mentioned factors could have influenced the reported findings; in excess of 53 per cent males and 33 per cent of females among the 15-24 year never married youth had knowledge of their peers’ experience on sexual intercourse which indicated substantial percentage among the unmarried youth had premarital sex. Among the unmarried male youth of 15-19 group, over 22 per cent had experience in sexual intercourse, while only 9 per cent of female youth had the same. The same survey further revealed that among sexually active 15-19 age group 60 and 57 per cent of males and females respectively used contraceptives to avoid unwanted pregnancies which indicated that more than one third of the never married youth who were sexually active had unprotected sex [7]. These findings highlight the importance of SRH among the youth in Sri Lanka and limited contribution by school education towards providing sexual and reproductive health (SRH) related information to the general community which could have further worsened due to COVID-19 pandemic [7-10]. This paper aimed to conduct a desk review on existing policies and strategies on sexual and reproductive health of adolescent and youth to identify the issues and deficiencies.

UNDER PEER REVIEW

2. METHODOLOGY

Two distinct methods were used for the study. Both components were conducted between June 2021 to December 2021 with first method followed by the second method.

2.1 First method

A comprehensive desk review of the policies and strategies on SRH of youth in Sri Lanka was conducted.

Two steps were used to ensure that all policies and strategies related to SRH of youth are included in the review.

2.1.1 First step

All Ministries and Departments which are concerned with the adolescents and youth were contacted to obtain the policies and strategies concerning SRH of adolescent and youth in Sri Lanka.

2.1.2 Second Step

Websites of all above mentioned Ministries and Departments were screened for policies and strategies. In addition, using "Google" search engine, online search was performed to capture the policies and strategies related to SRH of Adolescents and Youth.

2.1.3 Eligibility Criteria

Any published policy, strategy or Act **which were directly or indirectly related to Adolescents / Youth** AND **on Sexual and Reproductive health.**

UNDER PEER REVIEW

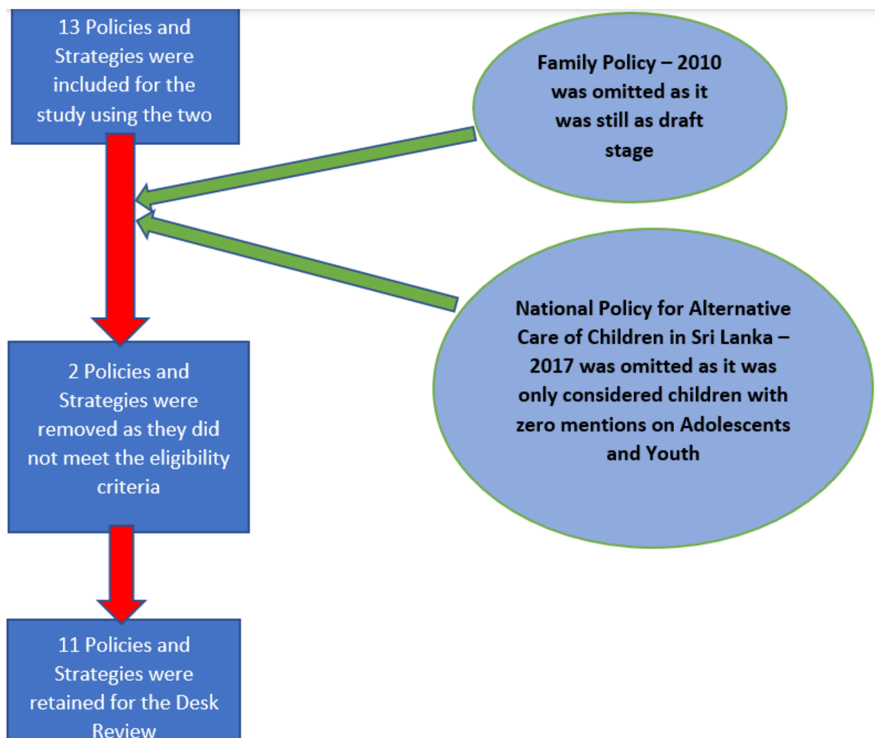

Figure 1- Selection of policies, strategies, frameworks and laws on youth SRH

Review of following policies related to the SRH of youth were conducted under the desk review.

a. National Youth Policy-2014 [11]

b. National Policy on Maternal and Child Health-2012 [12]

c. National Strategic Plan on Adolescent and Youth Health- 2018-2025 [13]

d. National Policy & Strategy on Health of Young Persons- 2015 [14]

e. Population & Reproductive Health Policy- 1998 [15]

f. National Child Protection Policy- 2019 [16]

g. National Policy for Alternative Care of Children in Sri Lanka- 2017 [17]

h. Information and Cyber Security Strategy of Sri Lanka- 2018 [18]

i. Domestic Violence Act- 2005 [19]

UNDER PE

j. National Health policy 2016- 2025 [20]

k. National HIV/ AIDS policy- 2011 [21]

Critical analysis of the above-mentioned youth policies and strategies with regard to SRH was conducted using the adequacy of coverage of below-mentioned key six domains of SRH as mentioned by World Health Organization [2].

1. Overall focus on Sexual and Reproductive Health
2. Comprehensive Sexual and Reproductive Health Education
3. Contraception counselling & provision
4. Safe abortion care
5. Sexually transmitted infections (STIs) and HIV prevention care
6. Violence against women and girls- prevention, support and care

2.2 Second Method

2.2.1 Focus group Discussions

Youth are the beneficiaries of the SRH youth policies in Sri Lanka. However, for youth to receive the benefits of SRH youth policies and strategies, not only should the SRH youth policies and strategies adequately cover the key elements, but also require the presence of implementation and budgeting plan with supportive environment including the legal and political backing. In addition, timely implementation with monitoring and evaluation is critical. Therefore, it was decided to conduct 3FGDs representing the following categories.

1. Male youth from Colombo district representing different sociodemographic backgrounds (sector-wise, highest education attained and employment status).

2. Female youth from Colombo district representing different sociodemographic backgrounds (sector-wise, highest education attained and employment status).

3. Female Muslim youth from Colombo district in State university education

Selection for the FGDs was carried out by the help of local Non-Governmental Organizations and Youth societies by the PI. FGD was conducted by the PI and the investigator team, who were playing the role of moderator and the note-taker. A place within the given community convenient for the study participants was selected. A time convenient for all the group members was considered in conducting the discussion. All FGDs were carried out in Sinhala

UNDER PEER REVIEW

language and for estate sector FGDs a translator was used to translate the questions and discussion from Sinhala to Tamil and vice versa. A semi structured guideline, translated to Sinhala was used as the tool. Thematic content and narrative methods were used for analysis of data

2.2.2 Key Informant Interviews

Using key informants, policy issues related to sexual and reproductive health of youth were investigated. For this purpose, a total of eight key informant interviews were carried out with an expert from Family Health Bureau working in youth and adolescent SRH; Two experts from Ministry of Education working in school going youth and adolescent SRH; Independent Educationalist working in youth and adolescent SRH; Two experts representing academics of university system working in youth and adolescent SRH; Legal Officer from an NGO working in youth and adolescent SRH issues; Researcher working in youth and adolescent SRH. Thematic content and narrative methods were used for analysis of data.

Ethical clearance was obtained from Ethics Committee, ChildFund, Sri Lanka (19/01).

3. RESULTS AND DISCUSSION

Data from the desk review and qualitative research methods namely FGDs and KIIs were summarized and discussed under the following six key thematic areas as identified by World Health Organization. Overall, implementation stages of all most all strategies in youth SRH plans and policies were either delayed, curtailed or non-implemented due to COVID-19 which further constricted already existing bottlenecks.

3.1 Overall focus on Sexual and Reproductive Health

Overall findings highlight the non-priority for SRH aspects in youth policies and strategic plans in Sri Lanka. The only policy/ strategic plan which covers the SRH aspects of youth adequately was the National Strategic Plan- Adolescent and Youth Health (2018-2025) by the Family Health Bureau [13].

Youth irrespective of the place of residence (urban, rural or estate) believe that lack of opportunities to express their views and ideas on sexual and reproductive health as one of the reasons for poor focus on sexual and reproductive health. Youth agreed that establishment of a separate Directorate to act as a bridging institute and a platform for youth to express their views and ideas on youth policy and strategies could improve the overall focus on SRH. The said Directorate should coordinate, forward and follow-up the received ideas and suggestions of youth to relevant authorities and Ministries (Ministry of Education, Ministry of Health, Ministry of Youth etc.) and should empower with the necessary mandate to carry out its functions. Importance of youth participation was highlighted as an important factor by Wigle and others “Recognizing and integrating young people in all stages of SRH policymaking is critical to catalyzing the social and political changes necessary to ensure their reproductive health and well-being.” [21].

UNDER PEER REVIEW

Further, key informants agreed that key local and international non-government organizations like UN agencies, and local non-governmental organizations and movements should lobby the key policy makers and legislators in Ministries of Health, Education, Youth and Law to include the youth as key stakeholders in formulation of key laws, polices and strategies of youth.

3.2 Comprehensive Sexual and Reproductive Health Education

Awareness of SRH policies and strategic plans among Sri Lankan youth is poor which could be considered as a proxy indicator on extent of the implementation of comprehensive sexual and reproductive health education in the country. Therefore, both key informants and youth agreed that major work is desired to implement the comprehensive SRH education in the country. Poor understanding of the definition of “policy” among the participants of focus group discussions was observed irrespective their age, gender, ethnicity, sector, level of education or employment status. None of the youth were able to differentiate the difference between “Law” and “Policy”. Zero participants were aware of the content of “National Youth Policy” or its existence. Similarly, none of the participants were aware of the National Strategic Plan on Adolescent and Youth Health of Family Health Bureau (2018-2025). This could be one of the major barriers against successful implementation of SRH youth policies and strategies in Sri Lanka. Unawareness among the youth prevents them from actively lobbing for the implementation of the key reforms/ directives stated in these policies and strategies. Therefore, it is essential that, youth awareness in these policies and strategies should be improved. Summary of suggestions put forward by the FGD participants are mentioned below [13].

1. Inclusion of teaching of important policies, strategies and laws which are directly relevant to adolescents and youth at schools. This could be included to a subject like Social Sciences.

2. Inclusion of important policies, strategies, and laws as an introductory subject in preparatory courses at all university degree programmes and vocational training programmes.

3. Social media campaign to enlighten the youth and adolescents in the country on important policies, strategies, and laws, (e.g., using Facebook, Tok-tok, YouTube etc.)

General agreement among the key stakeholders on implementation of compressive sexual education to schools observed though many disagreements on the process of implementation exist.

All key stakeholders in Education and Health sector unanimously agreed that comprehensive sexual education should be implemented in the country. However, there is general disagreement on following aspects on implementation process on CSE. They are, namely

1. The Grade (or age) of inclusion of contraception in CSE.

2. Level of skills and competencies of the teachers assigned to teach SRH

3. Learning aids for students on SRH

Below mentioned are the some of the quotes by the key informants on the Grade of inclusion of contraception at schools.

UNDER PEER REVIEW

“My personal belief is…. Our target should be to include teaching of contraception in Grade 11. Why? Still, we have observed many leaving schools after Ordinary Level despite efforts by the Ministry of Education to retain youth until they complete 13 years of school education. Therefore, if we don’t introduce contraception teaching in Grade 11, we will be missing important and vulnerable group of youth from providing CSE. However, practicality of such implementation at Grade 11 is a real issue. The environment at present is not conducive to such implementation. Therefore, for the time being, we might have to stick with the implementation and scaling up the CSE with contraception to Grade 12 students”

A Deputy Director at Ministry of Education

“We have not included contraception in SRH education up-to Grade 11. I feel at Grade 12 and 13, it might be appropriate to teach contraception. The issue is, there is no uniform curriculum when it comes to Advance Level or Grade 12 and 13 teaching.”

A recently retired Education Director at Ministry of Education

“I believe that contraception teaching should be included to Grade 12. Introducing contraception in Grade 11 is too early and could promote the use among the students. We need to think about the cultural aspects of the country. And at present, my personal belief is traducing contraception at Grade 12 should be enough”

A Director at Ministry of Education

“I believe that contraception also should be included in SRH curriculum at 15 to 16 years (Grade 10 to 11 students). One reason to teach contraception to above age group is that I have observed many students drop out from schools after O/Ls. There is a time gap of few months from the day of the O/L examination to the results of the O/L examination and the commencement of A/L at schools. Therefore, I have observed that many youth use this time to seek employment, sometimes in faraway places. Most of these youth would not return to schools to continue their education at A/Ls. These youth will not have the proper knowledge on contraception and are vulnerable as some of them are employed at faraway places from their homes and live in hostels or boarding places. Thus, ideal time to provide specific SRH knowledge on contraception would be at Grade 10 to 11.”

A senior academic in sociology from local university

“With the present socio-cultural and religious context, I doubt whether the contraception teaching can be included to Grade 10 to 11 students. That does not mean that it should not be taught at Grade 10 to 11 students. What I feel, is it should be taught at Grade 10 to 11 students as they are 15 to 16 years old and are old enough to learn contraception. Regarding the teaching, I feel that it is important to practically demonstrate the contraceptive methods. It will be very important to provide the skills to the students. If this could be done gradually from Grade 10, we could prevent majority of the SRH issues of youth. This is important as I have observed that youth are shy and reluctant to buy contraception form

UNDER PEER REVIEW

pharmacies or shops. This issue of shyness and reluctance to buy contraception in Sri Lanka could have resulted in teenage pregnancies and unsafe abortions later. Therefore, it is important to provide comprehensive sexual education starting from Grade 10 is very important to reduce this reluctance to buy contraceptives from shops due to the misconceptions of what the society would think of the concerned youth.”

A male youth from Colombo district employed in private sector

As highlighted by the report on comprehensive sexuality education (CSE) in Asia,~~: A regional brief,~~ only five out of the seven components in CSE integration in country laws and policies was covered in Sri Lankan education system, namely gender, SRH and HIV, violence, diversity and relationships. The deficient components were sexual rights and sexual citizenship and pleasure [22].

3.3 Contraception counselling & provision

Two laws (Kandyan and Muslim laws) reduce the possibility of any successful interventions on early and forced marriage. Key informants revealed that lobbying of amending above mentioned Acts were so far unsuccessful. However, ~~a~~ significant progress was made on provision of contraceptive services to couples living together irrespective of the age of the female partner. Many issues were faced by the health service providers following provision of contraceptives and SRH services to such couples with underaged female partner of less than 16 years in Sri Lanka. Many incidences were reported by the Medical Officers of Health and Public Health Midwives in the country where they were questioned and remanded by the Police for family planning service provision for less than 16-year-old females. Family Health Bureau, to curb this situation implemented the Circular “Providing Sexual and Reproductive Health Services to Adolescents” dated 25th January 2015 following the clearance from Attorney General Department. In the circular, it is stated that “Since non-disclosure of rape does not fall within the ambit of section 21 of the Code of Criminal Procedure Act and is therefore not punishable under section 199 of the Penal Code, healthcare workers including Medical Officers do not have the legal duty to inform law enforcement authorities of pregnancies among adolescents aged below 16 years, who accessed ASRH services”. In parall~~r~~el to this legal munity, awareness programmes were conducted targeting the Police Officers handling such cases to improve their knowledge and prevent such arrest or questioning of health officials in future. ~~And~~ F~~f~~ollowing the implementation~~ing~~ of this circular alongside the awareness campaign, these incidences were reduced significantly. This is one of the successful interventions on early and forced pregnancy but had minimal effect on reducing the early and forced marriage [24-25].

3.4 Safe abortion care

Induced abortion is illegal in Sri Lanka except in situations where mothers’ life is at danger. However, post-abortion care is provided in all hospitals where a Consultant Obstetrician is available. Though exact data is not available, it is estimated that a significant number of induced abortions take place in Sri Lanka. Illegal abortions and resulting complications have been a problem to the healthcare system of this country. Ministry of Health have issued guidelines on National Guidelines on Post Abortion Care in 2015 to assist the medical

UNDER PEER REVIEW

practitioners on provision of care. However, overall, both youth participants and key informants were in agreement that major amendments to abortion laws are~~is~~ required [25-26].

3.5 Sexually transmitted infections (STIs) and HIV prevention care

Family Health Bureau have ensured the inclusion of prevention and detection of STIs including HIV in all training programmes on SRH. This component of the training was conducted by experts from National STD/AIDS Control Programme in Sri Lanka. However, many youths revealed poor knowledge including prevention of STIs gained through formal education.

“Though we were taught little bit of the structure of reproductive organs and functions of some of these organs, we were not taught on STIs. Those days, we only knew about AIDs among the STIs. I feel that it is a big problem in educational system in Sri Lanka. Some sections of the SRH teaching are omitted most of the instances knowingly by the teachers”

However, as Agampodi and others have concluded in their study, majority of the youth who participated in FGDs were~~as~~ in agreement that adolescent health services are insufficient and available services are not being provided in an appropriate manner. Proper training of health care providers on youth friendly service provision is crucial. A National level integrated health care program is necessary for the adolescents [27]. Introduction of youth friendly health services “yowun piyasa” centers partially addressed the concern in 2014. However, human resource and financial issues have limited the expansion of these services thus restricting the effectiveness and reach.

3.6 Violence against women and girls- prevention, support and care

Strengthening the national programme for gender-based violence (GBV) of Family Health Bureau was initiated to address the deficiency in prevention, support and care of women and girls who are victims of violence. Under this porgramme as a ~~a~~ key intervention “Mithuru piayasa” centers were established in hospitals across Sri Lanka. “Mithuru Piayasa” centers act~~s~~ as ~~a~~ safe havens for victims of GBV and provide immediate access to safety & services. Further, these centers conduct target-oriented activities to build stable & independent lives and addresses physical and emotional needs of victimized youth. As a broader commitment, these centers together with the national programme intend to break the vicious cycle of domestic violence. However, many such youth victims of violence especially girls face traumatized legal process which require major changes. The report by Equality Now stated following issues in the legal process.

1. Fraud amongst law enforcement officers
2. Failure of the police to record cases of sexual violence
3. Lengthy delays in police investigation and trial of rape cases
4. The minimal conviction rate in rape cases (around 3.8%)
5. Continued use of the two-finger test

UNDER PEER REVIEW

6. Complexities in gain access to support services for survivors [28].

Comment [P5]: A section on Recommendations/Future directions would be a logical outcome of a review and fieldwork like this. It would really improve the significance of the article and provide explicit action points for relevant stakeholders to follow.

3.1 Limitations

We limited the participants for FGDs to Colombo District though we ensured adequate representation of ethnicities and sex. However, non-selection of participants from the estate sector was a limitation.

4. CONCLUSION

Overall findings highlight the non-priority for SRH aspects in youth policies and strategic plans in Sri Lanka. The only policy/ strategic plan which covers the SRH aspects of youth adequately was the National Strategic Plan- Adolescent and Youth Health (2018-2025) by the Family Health Bureau. Similarly, lack of priority for SRH aspects of Youth was evident in youth policies and strategic plans formulated by non-health governmental organizations. This was true for National Youth Policy. In addition, awareness of youth policies and strategic plans (including SRH) among Sri Lankan youth is poor.

General agreement among the key stakeholders on implementation of comprehensive sexual education to schools observed though many disagreements on the process of implementation exist among the stakeholders. Many deficiencies in both quantity and quality of SRH teaching at schools was observed with many were concerned on skills and competencies of teachers as well as lack of priority among principals at schools on SRH teaching. COVID-19 have impacted in both implementation of key interventions in many strategic plans and policies including National Strategic Plan on Adolescent and Youth Health (2018-2025).

CONSENT

Informed and written consent was obtained from participants of FGDs and KIIs.

ETHICAL APPROVAL

Ethical clearance was obtained from Ethics Review Committee of ChildFund, Sri Lanka (ERC Number- COVID 19/01)

REFERENCES

1. Lehtimaki S, Schwalbe N. Adolescent Health- The Missing Population in Universal Health Coverage. 2020.

UNDER PEER REVIEW

2. World Health Organization. WHO recommendations on adolescent sexual and reproductive health and rights. 2018. Accessed 20th April 2022. Available: http://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf?ua=1

3. World Health Organization. (2011). Advancing ASRH through human rights: strengthening laws, regulations and policies – Sri Lanka. 2011. Accessed 15th April 2022. Available: https://apps.who.int/adolescent/second-decade/section/section_8/level8_10.php

4. World Health Organization. Scaling up adolescent health in South-East Asia. 2014.

5. De Silva WI. Sri Lanka: Re-emergence of youth bulge. The National Centre for Advanced Studies in Humanities and Social Sciences, University Grant Commission, Colombo, 2016.

6. De Silva WI, de Silva R. Sri Lanka: 25 million people and implications - population and housing projections, 2012-2062. UNFPA, Colombo, 2015.

7. De Silva WI, Kumarasinghe M. Summary and Conclusion. In W. I. De Silva (Ed.), Sri Lankan Youth: Sexual and Reproductive Health (p. 214). ChildFund, Sri Lanka, 2020.

8. Family Health Bureau. National youth health survey 2012/2013, Sri Lanka. Colombo, 2013.

9. Talagala N. Unsafe abortions in Sri Lanka –facts and risk profile. Journal of College of Community Physicians of Sri Lanka. 2010;15(1), 1-12.

10. De Silva WI. A national study on adolescent sexual and reproductive health, Plan Sri Lanka, Colombo, 2008.

11. Ministry of Youth Affairs and Skill Development. National Youth Policy. Ministry of Youth Affairs and Skill Development, Sri Lanka. Colombo, 2014. Accessed 16th March 2022. Available: http://www.ou.ac.lk/sites/nypsl/YPEnglish-Book.pdf

UNDER PEER REVIEW

12. Family Health Bureau. National Policy on Maternal & Child Health. Family Health Bureau, Sri Lanka. Colombo, 2012. Accessed 13th March 2022. Available: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/4_Maternalper cent20andper cent20Childper cent20Health.pdf

13. Family Health Bureau. Strategic Plan on Adolescent and Youth Health 2018-2025. Family Health Bureau, Sri Lanka. Colombo, 2018. Accessed 3rd March 2022. Available: http://yowunpiyasa.lk/images/Guidelines/sp/SP.pdf

14. Ministry of Health. National Policy & strategy on Health of Young Persons. Ministry of Health, Sri Lanka. Colombo, 2015. Accessed 2nd March 2022. Available: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/PolicyRepository.pdf

15. Ministry of Health. Population & Reproductive Health policy. Ministry of Health, Sri Lanka. Colombo, 1998. Accessed on 27th February 2022. Available: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/3_Populationper cent20andper cent20Reproductive.pdf

16. National Child Protection Authority. National Child Protection Policy. National Child Protection Authority, Sri Lanka. Colombo, 2019. Accessed on 4th February 2022. Available: http://www.childprotection.gov.lk/documents/Nationalpercent20Childpercent20Protectionpercent20Policypercent20-percent20finalpercent20-percent202013.10.4.pdf

17. Department of Probation and Child Care Services. National Policy for Alternative Care of Children in Sri Lanka. Ministry of Women and Child Affairs, Sri Lanka. Colombo, 2017. Accessed on 10th February 2022. Available: http://www.probation.gov.lk/documents/downloads/Draft%20Alternative%20Care%20Policy.pdf

18. Sri Lanka Computer Emergency Readiness Team Information and Cyber Security Strategy of Sri Lanka 2019-2023. Ministry of Digital Infrastructure and Information Technology, Sri Lanka. Colombo, 2018. Accessed on 15th February 2022. Available: https://cert.gov.lk/documents/NCSStrategy.pdf

UNDER PEER REVIEW

19. Parliament of the Democratic Socialist Republic of Sri Lanka. Prevention Of Domestic Violence Act, No.34 OF 2005. 2005. Accessed on 2nd February 2022. Available: https://www.refworld.org/pdfid/4c03ba2f2.pdf

20. Ministry of Health. National Health Policy 2016 – 2025. Ministry of Health, Sri Lanka. Colombo, 2016. Accessed on 1st March 2022. Available: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/policiesUpto2016/policiesForPublicOpinion/NHP2016-2025draft.pdf

21. Wigle J, Paul S, Birn AE, Gladstone B, Braitstein P. Youth participation in sexual and reproductive health: policy, practice, and progress in Malawi. Int J Public Health. 2020;65(4):379-389. doi:10.1007/s00038-020-01357-8

22. Shahbaz S, Chaudhry I, Arinii R. Comprehensive Sexuality Education (CSE) In Asia: A Regional Brief. 2018. ISBN 978-967-0339-42-9

23. Rajapakse R. An Introduction to Law in Sri Lanka; Chapter V11; Marriage, Divorce & Family Obligations. Stamford Lake (Pvt) Ltd, Sri Lanka, Colombo, 2006.

24. Family Health Bureau. Circular Letter: Providing Sexual and Reproductive Health Services to Adolescents dated 25th January 2015. Ministry of Health, Sri Lanka. Colombo, 2015.

25. Ministry of Health. National Guidelines on Post Abortion care. Ministry of Health, Sri Lanka. Colombo, 2015.

26. Women on Waves. Abortion Law in Sri Lanka. Women on Waves, 2022. Accessed on 15th February 2022. Available: https://www.womenonwaves.org/en/page/4894/abortion-law-sri-lanka

27. Agampodi SB, Agampodi TC, Piyaseeli UKD. Adolescents perception of reproductive health care services in Sri Lanka. BMC Health Serv Res, 2008;8: 98. https://doi.org/10.1186/1472-6963-8-98.

UNDER PEER REVIEW

28. Equality Now. Sexual Violence in South Asia: Legal and Other Barriers to Justice for Survivors. Equality Now, 2021. Accessed on 2nd January 2022. Available: https://d3n8a8pro7vhmx.cloudfront.net/equalitynow/pages/3578/attachments/original/1618920590/Sexual_Violence_in_South_Asia_Legal_and_other_Barriers_to_Justice_for_Survivors_-_Equality_Now_-_2021_%281%29.pdf?1618920590

UNDER PEER REVIEW