Maternal, newborn and child health

HEALTH AND EDUCATION SECTOR COLLABORATION IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN SRI LANKA

A situational analysis and case study of the Kalutara District

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ACRONYMS

ADB	Asian Development Bank
AGA	Assistant Government Agents
AIDS	Acquired immune deficiency syndrome or acquired immunodeficiency syndrome
ASRH	Adolescent sexual and reproductive health
CEPA	Centre for Poverty Analysis
CIHC	Canadian Interprofessional Health Collaborative
CPR	Contraception prevalence rate
DoCS	Department of Census and Statistics
DSW	Deutsche Stiftung Weltbevolkerung or The German Foundation for World Population
EMRO	Eastern Mediterranean Office of the World Health Organization
EPD	Education Publications Department
Estates	Plantation areas that are largely privatised
FGD	Focus group discussion
FHB	Family Health Bureau
FP	Family planning
FPA	Family Planning Association
GCE	General Certificate Education
HIV	Human immunodeficiency virus
HR	Human resources
HRH	Human resources for health
IPE	Interprofessional education
JICA	Japan International Cooperation Agency
KAP	Knowledge attitude practice
KII	Key informant interviews
MCH	Maternal and child health
MDG	Millennium development goal
MMR	Maternal mortality ratio
MO	Medical Officer
MoE	Ministry of Education also known as Ministry of School Education
MOH	Medical Office of Health
MoH	Ministry of Health also known as the Ministry of Health and Nutrition
MoHN	Ministry of Health and Nutrition also referred to as the Ministry of Health
MoHRD E&CA	Ministry of Human Resources Development, Education and Cultural Affairs
NGO	Non-government organisation
NIE	National Institute of Education
NIH	National Institute of Health
NYSC	National Youth Service Council
PDHSWP	Provincial Directorate of Health Services, Western Province Sri Lanka
PHC	Primary health Care
PHI	Public health inspector
PHM	Public health midwife
PHNS	Public health nursing sister
pirivena	Monastic colleges for the education of Buddhist priests
PROAP	Principal Regional Office for Asia and the Pacific
RHIYA	Reproductive Health Initiative for Youth in Asia
SBA	Skilled birth attendance
SEARO	South East Asia Office of the World Health Organization
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
STD	Sexually transmitted disease
UN	United Nations
UNAIDS	United Nations Fund for AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YFHS	Youth Friendly Health Services

A note about the use of acronyms in this publication

Acronyms are used in both the singular and the plural, e.g. MDG (singular) and MDGs (plural).
Acronyms are also used throughout the references and citations to shorten some organisations with long names.

KEY MESSAGES

- Adolescent sexual and reproductive health (ASRH) issues are multi-factorial and are underpinned by biological as well as social determinants. These issues include sexual abuse, family dysfunction, poor parenting, poverty, low education and socio-cultural issues. In addition, service delivery gaps affect adolescent use of facilities and access to information. This complex environment demands inter-sectoral interventions and the collaboration of human resources (HR) beyond health.
- A minimum package of adolescent sexual and reproductive health services and a service delivery model should be developed between health and education sectors. This can address provider, knowledge and skills gaps, attitudinal issues, provide support and encourage team work thereby enhancing health outcomes for adolescents.
- Such a package requires workforce collaboration between primary health care workers, teachers and counsellors which should be fostered through cross cadre team-based approaches to education and training, clear referral pathways between sectors and performance management.
- This collaboration must be supported by appropriate ASRH policy, adequate funding, planning and legislation across both the health and education sectors.
- Adequate monitoring and evaluation of ASRH programs in the health and education sectors is needed and must take into consideration HR issues and broader contextual factors in order to contribute to on-going quality improvement of ASRH programs.

EXECUTIVE SUMMARY

Cross cadre collaboration is therefore necessary across **health, education, media and social services to realise large, sustained impacts on ASRH outcomes.**

Adolescence is a period of rapid physical, emotional, social and cultural transition for 10 to 19 year olds who comprise nearly a third of the world's population. Eighty-eight percent of the world's adolescents live in developing countries and their ASRH outcomes are disproportionately poorer than other groups. ASRH is recognised as an important area of public health concern and international commitment to improving sexual and reproductive health is demonstrated in many of the Millennium Development Goal (MDG) targets.

The World Health Organization (WHO) acknowledges the complex nature of adolescent health determinants and recommends that an inter-sectoral approach is required beyond the health sector. Cross cadre collaboration is therefore necessary across health, education, media and social services to realise large, sustained impacts on ASRH outcomes. Despite this, little is known about how collaboration occurs between professionals and how this can be better supported to improve adolescent health.

There is a paucity of knowledge concerning the roles of those who provide services, care and information across the health and education sectors, how they are managed and educated, and the policies that guide their practice. This report outlines the results of a case study to identify factors that contribute to improving the ability of health and education providers to collaborate and develop ways forward for human resources policy and practice.

A district in Sri Lanka was selected to explore cross cadre collaboration across the health and education sectors in ASRH, as the country has made considerable progress towards reducing maternal mortality and providing access to reproductive health and primary education (MDGs 5 and 2). In addition a study from the viewpoint of a well established primary health care and education work force may provide insights that could be transferred to other developing countries. The case study involved a desk review of documentation, focus group discussions and interviews

with teachers and health workers, and a survey of the ASRH knowledge, attitudes and practices of teachers and health workers. The findings provide insight into providers' perceptions of adolescent needs and issues which include lack of ASRH knowledge and access to counselling and condoms, poor parental support exacerbated by poverty and low education, as well as issues related to the values and beliefs underpinning Sri Lankan culture and society.

Health workers and teachers stated that ASRH services were limited, short term and not widely evaluated and that there was a need to increase demand through improved funding and comprehensive policy support. Providers felt that the ASRH education delivered through the school curriculum could be strengthened through better alignment with culture and the introduction of an on-going year length course that includes biological as well as social and emotional aspects.

A number of useful ASRH initiatives were discussed but respondents felt these needed to be better integrated into the school programs. Student counselling in schools was regarded as an important service but issues of confidentiality and low demand were reported to affect the service.

The study provided an understanding of the workforce issues experienced by teachers and primary health care workers in relation to ASRH. Provider roles were generally perceived to be focused on the provision of education, counselling and advice. Raising awareness of ASRH issues and establishing relationships with youth, their families and related agencies was also regarded as important. Participants highlighted a number of concerns with management practice that were said to affect their ability to undertake certain tasks.

According to providers, ASRH duties were not included in their job descriptions which impacts upon the quality of staff appraisal and the evaluation of services. Some duties, such as counselling, were taken on by staff without adequate training and staff felt their workloads were already large. However, many reported that they received good supervision and support from superiors. High staff turnover was noted in teacher counsellor roles, as was a shortage of counsellors in rural areas.

Teachers and health workers noted issues with the lack of pre and in-service training in ASRH and requested up-to-date resources for learning and teaching. Health worker knowledge and skills gaps were identified in relation to contraception, and both teachers and health workers reported feeling uncomfortable and lacking confidence providing ASRH

Teachers and health workers noted issues with the **lack of pre and in-service training in ASRH** and requested up-to-date resources for learning and teaching.

information and services. All participants discussed the need for inter-sector alignment and collaboration in ASRH through policy across health and education. Such policy would work to clarify their individual and team roles and formalise relationships among professionals so responsibility could be shared. A single service point at community level to deliver ASRH services and information was regarded as useful to direct all referrals, however, essential to all work was the need for all providers to build relationships with youth and other agencies. These findings indicate the need for the development of a minimum package of ASRH services and a service delivery approach that includes inter-professional education and training, team work and cadre mix approaches with clear referral protocols. This requires a program-based approach that is woven into the policy and action plans of all agencies involved.

The report presents a framework to improve cross cadre collaboration across the health and education sectors to enhance the delivery of ASRH care and information. The framework highlights inter-professional education and training and performance management for health workers and teachers designed to guide practice, clarify roles and develop strong relationships across the sectors. The framework ties these important HR aspects with clear ASRH policy, dedicated funding, planning and legislation with adequate program monitoring and evaluation for continuous improvement. This may serve as a model for ASRH work across other sectors including justice, youth and social welfare and also serve as a model for other low income countries to adopt.

INTRODUCTION

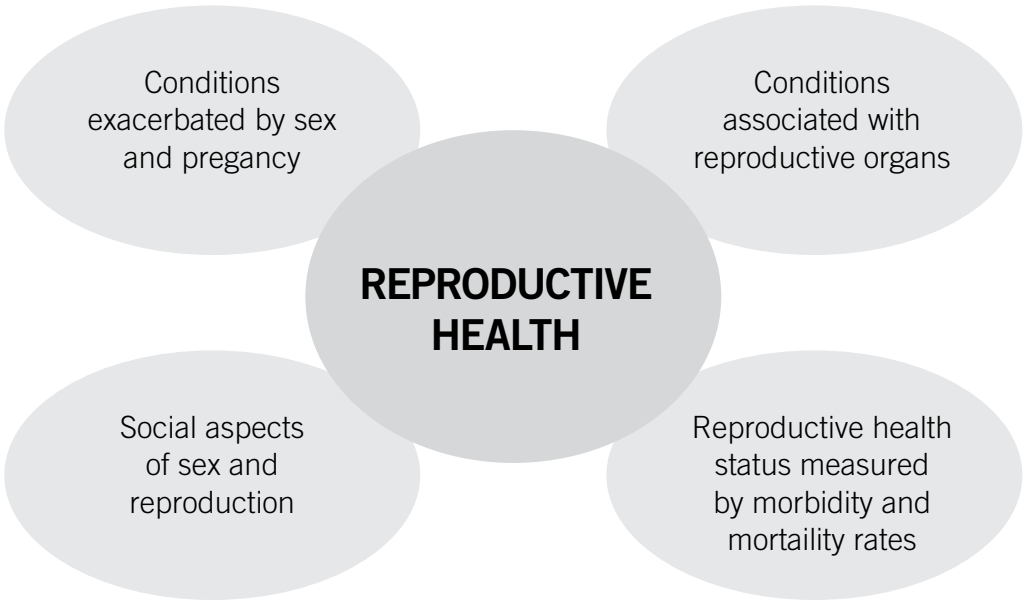
What is adolescent sexual and reproductive health?

Adolescence, defined by the World Health Organisation (WHO) as occurring between 10 and 19 years of age, is a time of rapid physical, psychosocial and emotional change. For the 1.2 billion adolescents (nearly a third of the world's population) it is a unique period of life. This is characterised, on the one hand, by the increasing physical capacity to be sexually active and conceive a child. On the other hand, a less than fully developed cognitive and psychosocial capacity inhibits the ability to assess the unintended consequences of sexual activity, and negotiate safe and consensual sex. For adolescents in low income countries, these developmental and socio-economic vulnerabilities lead them to experience a disproportionate burden of reproductive and maternal morbidity and mortality (Viner 2011). As a result adolescents have been specifically targeted in MDG 5.

Adolescent reproductive health is a broad concept that addresses the reproductive processes, functions and system. It refers not only to the biological dimensions of health but also to social and psychological aspects of well-being. Reproductive health implies that adolescents are able to have a responsible and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Inherent in this is the fact that adolescents have a right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, as well as the right to access appropriate health care services.

A number of definitions have been proposed to assist in describing and measuring reproductive health (Busza and Lush 1999). Figure 1 outlines four domains or dimensions that cover biological, social and psychological aspects of reproductive health. Reproductive health status is measured by indicators such as maternal mortality rates (MMR) and contraceptive prevalence rates (CPR) which are also used to assess progression toward the MDGs. Another aspect of reproductive health are the conditions associated with the reproductive organs such as HIV/AIDS, sexually transmitted diseases (STDs), maternal haemorrhage, maternal sepsis and cancers of the breast, cervix and prostrate. Conditions exacerbated by sex and pregnancy include post-natal depression and anaemia, while social aspects of sex and reproduction cover issues such as gender discrimination.

FIGURE 1. DOMAINS OF REPRODUCTIVE HEALTH



Focus on the workforce who delivers ASRH care, services and information

The training, competencies and support of professionals that are engaged in delivery care, service and information to adolescents at the primary level has been the focus of many global initiatives. A recent WHO document has set out the core competencies expected of primary health care workers in ASRH that cover attitudes, leadership and management, education, counselling and assessment and clinical skills (WHO 2011). In addition the WHO has produced orientation guides to train health workers (WHO 2003) and guidelines for ASRH in nursing and midwifery curricula (WHO 2004). Job Aides are also available for primary health care workers (WHO 2010). Numerous curricula and tools have been developed for education providers (WHO 2001; UNESCO 2005; UNICEF 2009).

Adolescent reproductive health is therefore multi-dimensional and concerned with targeting various health conditions requiring the skills of many professionals. It is necessary to ensure that the approach is broad enough to address the range of factors affecting outcomes. This includes the implementation of policy and interventions that go beyond health, and the coordination of ASRH services so that they are accessible, acceptable and cost effective. In order to achieve these goals WHO has identified key areas of work. These are:

- to collect, analyse and use data on adolescent health to support and inform policy making;
- to develop evidence-based policies and programs that support adolescent health; to increase access to and use of health services for adolescents;
- to strengthen contributions from the education, media and other sectors to improve adolescent health (WHO 2008).

The work described in this report makes a contribution towards the first area of work. The report provides important information about how health and education personnel deliver information and services to adolescents in a selected district in Sri Lanka. This knowledge provides insight into how policy and practice can be improved.

ASRH in Sri Lanka

An investigation into health and education provider collaboration in ASRH in Sri Lanka provides a useful case to glean insight into such practices in a context where considerable progress has been made towards improving maternal and reproductive health outcomes. The professionalisation, broad coverage and use of midwives (Levine 2007) has been a central feature of reducing the MMR from 250 per 100,000 births in 1935 to 58 in 2010, and the skilled birth attendance rate from 30% of the births in 1940 to nearly 99% in 2010 (de Silva 2007; WHO 2010). Universal health coverage is delivered by a multi-disciplinary team who provide free access to health care for adolescents at primary care level. Despite this, several recent changes, including decentralisation and ongoing conflict, have undermined primary care delivery. Much work has been undertaken to establish adolescent health-seeking behaviour and perceptions (UNICEF 2004; Dissanayake 2006; Agampodi 2008). However, there are no studies to date that examine the perspectives of providers, particularly those of primary health care workers and teachers.

Gender inequalities can negatively affect the pace and quality of health and development, and a national survey of **Sri Lankan adolescents cited gender and racial discrimination as among the main problems they faced.**

Adolescents in Sri Lanka comprise nearly 20% of the population, constituting the largest proportion of the population group for both sexes (DoCS 2008). Sri Lanka has made considerable progress towards addressing MDG 5, however, there are still gaps reflected in adolescent health and social indicators. Despite an overall low adolescent fertility rate, in the estate sector (plantation areas which are largely privatised) this is nearly double (DoCS 2008). Skilled birth attendance (SBA) for 15-19 year-olds is high at 98.3% (DoCS 2008), although data from Northern Province is not included where SBA is thought to be much lower. There is a paucity of available data for unmarried adolescents. Only 44.7% of currently married women 15-19 years of age reported using modern contraceptive methods and, although high numbers of 15-19 year-olds report having heard about HIV/AIDS, there are still considerable knowledge gaps concerning the use of condoms for prevention (DoCS 2008) and the signs and symptoms of sexually transmitted infections (UNICEF 2004).

Gender inequalities can negatively affect the pace and quality of health and development, and a national survey of Sri Lankan adolescents cited gender and racial discrimination

as among the main problems they faced (UNICEF 2004). Low education and poverty may also reduce some protective factors associated with promoting adolescent well-being such as safe and protective environments. Nearly 10% of early adolescents and 14% of mid and late adolescents admitted to having been sexually abused (DoCS 2001), with youth in the estate sector at greater risk (Dissanayake 2006). Socio-cultural and legal factors in the country also strongly affect the open and free discussion of issues of sexuality (UNESCO PROAP 1999). Abortion is illegal, unsafe and on the rise, with one-fifth of abortions occurring among adolescents (Silva 1997).

Need for inter-sectoral partnership

These health and social indicators provide evidence for the need for greater attention on adolescent reproductive health issues (Abeykoon 1998). In addition, specific focus should be given to unmarried adolescents' needs, and the increasing demand for services and information in the Estate sector and Northern Province where there is a paucity of data (De Silva 2003). The multi-factorial nature of adolescent reproductive health issues, which involve biological as well as social determinants, demand complex interventions. This not only requires integrated services and team approaches across health (WHO/UNICEF/UNFPA/UNAIDS 2007), but also inter-sectoral interventions and the collaboration of HR beyond health in order to realise large, sustained impacts (Hughes 1998; Speizer 2003). This is acknowledged in a WHO framework which highlights the important role of the health, education, social services and media sectors when addressing adolescent needs for information and life skills, health and counselling services, safe and supportive environments and opportunities to contribute and participate (WHO/EMRO 2006).

ASRH is recognised as a priority area in Sri Lanka. The fourth goal of the latest Population and Reproductive Health Policy (1998) aims to: ensure adequate information on population, reproductive health and family life, and sexuality in school curricula; strengthen youth worker education, especially on sex-related issues; and, encourage counselling on human sexuality. The Sri Lankan Family Health Bureau within the Ministry of Health and Nutrition (MoHN) has begun to establish a network of stakeholders at different levels to coordinate adolescent health programs. This approach involves the Department of Education, the National Youth Service Council (NYSC), and non-government organisations (NGOs) working in this field. In addition, the Family Planning Association of Sri Lanka, the Ministry of Education (MoE), local governments and a coalition of six NGOs collaborated on a European Union and United Nations Population Fund (UNFPA) adolescent reproductive health project (UNFPA/DSW 2003). These efforts recognise the important role that health, media, education and youth workers play. However, there are no clear guidelines from a human resource perspective concerning cross cadre collaboration nor have HR elements of these initiatives been evaluated. This is exacerbated by a lack of a human resources policy and development plan (MoHNW/JICA 2003). A recent study has outlined the lack of health workers with necessary skills and experience in ASRH (Shankar 2008) and another study recommends more research and an inter-sectoral approach that is supported by public health policy and legislation (De Silva 2003). Other research studies have also called for collaboration between the health, education, social, cultural and legal sectors to better address ASRH problems (Ratnayake 2002; Agampodi 2008; Mirkuzie 2008). A meeting of the National Adolescent Health Program Managers in the South-East Asia Region, which included Sri Lanka, called upon the health sector to contribute to the strengthening of other sectors to enhance adolescent health outcomes (WHO 2008).

Despite an initial commitment to and continuing interest in inter-sectoral action, there is a lack of leadership. The Population and Reproductive Health Policy (1998) is out of date and the National Policy on Health for Young Persons remains in draft form. Two key health policies, the National HIV/AIDS Strategic Plan (MoHN 2007), which is currently under review, and the National Maternal and Child Health Policy (MoHN 2008), state the need to increase the engagement and capacity of key ministries to deliver ASRH. Despite this, it is not clear how education and health providers will be supported to carry out this work.

Human resource collaboration across the sectors

A partnership approach to building the capacity of human resources across the health, education and social welfare sectors may enhance collaborative practice in ASRH care. However; this involves sustained policy, management and training interventions, as well as the participation of adolescents and their families. A WHO report (Bond 2004) identifies a number of HR inputs and processes that are required to carry out and sustain successful inter-sectoral ASRH programs. This includes developing appropriate selection and recruitment criteria, pre and in-service training, supervisory mechanisms and compensation for facilitators, teachers, counsellors, health workers and peer educators. Team approaches are central to the delivery of care and

services in the health sector. Effective primary health care teamwork can contribute to the improved management of health conditions (Bower 2006) and treatment compliance (Smith 2007), but can also offer health workers supervisory support (Hyrkas 2002; Hyrkas 2003) and learning opportunities (Townend 2005).

Inter-professional education and training (IPE) may contribute to efforts to enhance collaboration across sectors (WHO 2010). However, this needs to be aligned with organisational systems (Naccarella 2010) such as a team-based performance management system and service delivery model. There is some evidence that IPE may improve departmental culture, collaborative team behaviour and health professional competencies, as well as reduce clinical error rates (Reeves 2008). Despite this evidence, little is known about how health workers collaborate with teachers and counsellors and what inter-professional learning and work-based performance approaches might be appropriate and relevant in an ASRH context in Sri Lanka.

Conceptual framework for collaborative workforce practice and improved performance

This research is informed by a number of conceptual frameworks based upon systems thinking (Holden 2005). It considers ASRH human resources issues in relation to the achievement of the MDGs and health systems strengthening efforts, including service delivery enhancement and quality workforce practices. The complex nature of adolescent reproductive health determinants means that country progress towards universal access to reproductive health requires a focus on a number of MDGs, not just MDG 5.

This includes attention to improving gender equality and women's empowerment (MDG 3), increasing primary education (MDG 2) for girls and eradicating extreme poverty and hunger (MDG 1). Health system strengthening approaches also acknowledge that the health system is complex and, according to the WHO model, comprised of six building blocks: human resources for health (HRH), service delivery, finance, governance and leadership, information systems and supply of medical products, vaccines and technologies (WHO 2007). These blocks are interconnected and constantly adapting as a result of multiple and complex interactions among them. Improvements in the system can therefore only occur through interventions that target one or multiple system building blocks (de Savigny 2009). Also, health systems are not stand alone – they need to constantly interact with other systems at the micro and macro level in order to ensure the achievement of health and development goals. This includes human service systems such as education and social welfare, as well as socio-cultural, political and economic systems.

... Country progress towards universal access to reproductive health requires a **focus on a number of MDGs, not just MDG 5**

Holistic, non-linear approaches that consider human resource as well as service delivery aspects in ASRH programs that cross the health and education sectors have been found to offer a higher likelihood of success (Kirby 2001). Evidence from a small number of studies suggests that approaches that focus on health worker, teacher and counsellor training and mobilisation, and integrate a number of interventions, may increase adolescent demand for information and services (WHO 2003; Pande 2006). Importantly, the training provided to health professionals in these examples was conducted separately. It is postulated that inter-professional activities that involve providers learning and practicing together in teams, with some common performance assessment guided by common policy and regulations, may enhance performance in complex ASRH settings.

There are a number of frameworks that may be helpful to conceptualise the relationships between these professionals. These range from a focus on competencies (Clay-Williams 2009; CIHC 2010), curriculum delivery models (McNair, Brown et al. 2001; Jiffry 2002; Cullen, Fraser et al. 2003) and performance management (Andersen 2010; Cooper 2010). These are, however, mostly focused on developed clinical settings with health professionals highlighting a need for a model that encompasses primary health care workers, teachers and counsellors specific to ASRH in developing contexts.

There is therefore a need for an evidence informed model that brings together inter-sectoral policy, planning and regulation. The pre and in-service education training and performance management of primary health workers and teachers, if done collaboratively, can help to conceptualise the ASRH team, bring in key stakeholders and acquire the support required to deliver comprehensive care and services in Sri Lanka. The findings of this research will provide the evidence base for this much needed framework to inform policy directions and workforce practice across the health and education sectors in ASRH.

METHODOLOGY

This project involved an in-depth case study in the Kalutara district to explore gaps in health care delivery, and the feasibility of cross cadre collaboration across the health and education sectors to optimise health outcomes for adolescents in Sri Lanka. The study was comprised of four components: a review of documentation, focus group discussions and interviews with teachers and health workers, survey of the knowledge, attitudes and practices of teachers and health workers.

Research questions

The study research questions were designed to establish the current ASRH situation in Sri Lanka, including provider practice, and elicit the provider's views concerning adolescent reproductive health issues, the services that are delivered, workforce practices and interventions that may help to address barriers and constraints to practice. These questions are outlined below.

1. What are adolescent issues and needs in sexual and reproductive health?
2. What ASRH services are delivered, who delivers them and how across the health and education sectors?
   - How are providers managed?
   - How do providers work together, who do they talk to, what relationships do they have?
   - What policies guide practice in this area?
   - What funding is set aside and how for HR relating to ASRH?
   - What education and training do they receive in ASRH?
   - What are the attitudes, knowledge and practice of professionals in these areas in ASRH
3. What are ASRH services at the primary health care (PHC) level and how should they be delivered?
   - What dimensions should they cover?
   - Who should be involved?
4. What are the HRH barriers and constraints to addressing ASRH and why? How does this impact on HR performance and ASRH outcomes?
5. What interventions are required to address these barriers and constraints, how feasible are these interventions and what support is required for their implementation?

Review of available and relevant publications

A review of existing literature on ASRH in Sri Lanka from the electronic bibliographic databases PubMed, Medline and CINAL was retrieved using the key words "Adolescent" and "Sri Lanka" and "reproductive health". This was supplemented by searches for grey literature using the same key words on the websites of organisations including UNFPA, UNICEF and Family Planning Sri Lanka. Existing epidemiological, health service and educational data was sourced from government websites and reports. The material was appraised using criteria based upon the research questions and the veracity of the methods, findings and interpretation (Lucas 2007). A scoping exercise was also undertaken to identify key stakeholders and map out the services, projects and organisations involved in ASRH in the selected district and at regional and national levels.

Key informant interviews (KIIs) and focus group discussions

Focus group discussions (FGDs) were undertaken within similar cadres allowing participants to talk freely without feeling hindered by matters of status or socio-cultural factors. Separate FGDs were held for Estate midwives as these health providers were mainly Tamil speaking and likely to have different issues to other PHC workers (mainly Sinhalese speaking). Male/female teacher FGDs were also conducted separately. KIIs were conducted for school principals as their schedules made it more difficult to bring them together for a group discussion.

An interviewer question guide consisting of open-ended and probing questions was developed in English, Tamil and Sinhalese. Data was collected by a male medical officer and male research assistant; FGDs and KIIs were conducted at schools, estate health centres and district medical offices. Discussions were recorded via audio tape and transcribed into Singhalese and Tamil and then into English. These were then back translated to check for accuracy.

Knowledge attitude practice (KAP) survey

A questionnaire consisting of closed questions to establish the ASRH knowledge, attitudes and practices of teachers and health workers was given to all participants to complete. Responses were written by participants in Sinhala and then translated into English.

Research sites in Sri Lanka

This research is a pilot in order to determine the feasibility of a larger scale study that will be undertaken across Sri Lanka. The District of Kalutara was purposefully selected for convenience, and the demographic and geographic variation it provides. The District is south of Colombo on the west side of the country and is comprised of 13 Divisions (see appendix 1 for a map of all Medical Office of Health (MOH) in the District

and appendix 11 for an outline of health indicators in the District).

Selection of participants

All potential participants were sent generic written invitations to participate in the study with a return slip to indicate their interest, or not, in participating in the study. These were distributed in all health centres, school staff rooms and posted to schools in the district. Potential participants posted their slips in a pre-stamped envelope to the researchers at the University of Jayewardenepura, or placed them in a locked box at the MOH.

Some also sent a SMS or email message to communicate their interest. Those that indicated their willingness to take part were informed of the days and times that the FGDs were to take place. This was negotiated with the Director of the MOH, school principals, Estate managers and the Divisional Secretaries so that there was minimal impact on the participant's work. The travel and accommodation costs of all FGD participants were covered and a per diem allowance was provided.

Ethical and administrative considerations

Ethical clearance for the study was obtained from the UNSW Human Ethics Committee and the University of Jayewardenepura Medical Ethics Committee, and support was granted by the Director of Education Training & Research in the Department of Public Health in Sri Lanka.

Participants were given a copy of their signed consent form, which contained a revocation of consent section. If participants wished to withdraw from the study at any time they could sign the revocation section and return it to the researchers at the address shown. Participants were assured that withdrawal would not jeopardise any present or future relationship with the individuals or institutions concerned.

Data analysis

Document analysis

The documentation was analysed using a pre-determined framework (Pope, Ziebland et al. 2000) to categorise information according to key aspects of ASRH health and education service delivery and the related workforce profile. This enabled a profile of the current ASRH context in Sri Lanka at national and regional levels to be developed from the available documentation.

Focus group discussions and key informant interviews

A template approach to content analysis described by Miller (1992) was used to analyse the qualitative data retrieved through focus group discussions and key informant interviews. The following process was followed to code the interview data.

1. A pre-defined template was developed to identify particular elements in the documents according to research questions.
2. All transcripts were searched and items coded as per key pre-determined theme areas.
3. Categories were developed under the theme areas and revised.
4. Concept maps were developed to extrapolate links and patterns across all areas.
5. Theory was built from findings.

The rigour of the analysis process was enhanced through ongoing discussion between the researchers who agreed upon themes for the template and revisions of the categories.

Knowledge, attitude and practice survey

The data was entered into SPSS and descriptive analysis was undertaken to establish frequency of responses to the questions.

FINDINGS: REVIEW OF AVAILABLE AND RELEVANT PUBLICATIONS

Adolescent reproductive health care service delivery in Sri Lanka

In Sri Lanka the management of health care and services is decentralised with authority residing at the provincial, district and finally divisional levels. At the national level key departments involved in national policy and strategic planning in ASRH and HRH training under the Director General of Health Services include Public Health Services and the Education, Training and Research departments. The former department includes the National STI/AIDS Control program, Youth Elder and Disabled Services, Maternal and Child Health under the Family Health Bureau, Public Health Nursing, Estate and Urban Health and the Health Education Bureau. The medical services department focuses on curative care. See appendix 2 for a chart outlining the organisation of the Ministry of Health and Nutrition.

In each Province, Preventive Health Services consist of a network of MOH areas which are the main units for the management of all preventive and promotive health activities (See appendix 3 and 4). These MOH areas usually serve one Divisional Secretary Area. In the Western Province, for example, there are 35 MOH areas – 12 in Colombo district with 10 Assistant Government Agents (AGA) divisions, 15 in Gampaha district with 14 AGA divisions and 8 in Kalutara district with 13 AGA divisions (see appendix 1). Each MOH area is subdivided into Public Health Midwives areas, which constitute the smallest working unit in the government system.

The community health field team consists of public health personnel comprising one or two public health nursing sisters (PHNSs), four to six public health inspectors (PHIs), one or two supervising public health midwives (SPHMs) and 20 to 25 public health midwives (PHMs). Health personnel at district level are distributed according to areas. For example, in Kalutara each MOH area is divided into circuits for each PHM and for PHIs (table 1).

In Sri Lanka, at PHC level, care for adolescents is available without charge and provided by a workforce that includes medical doctors, midwives, nurses and health inspectors. Sri Lanka's health gains have been associated with the strength of its PHC system. However, this has been eroded in recent times resulting in an imbalance in the provision of services. Decentralisation has resulted in confusion between the responsibilities of the province and the district. A lack of commitment and capacity to operationalise devolved functions at district and divisional levels has further affected the delivery of PHC services (MoHNW/JICA 2003). In addition, conflict has impacted upon the health care system creating new challenges involving the delivery of care to internally displaced and remote populations.

Medical officers

A medical officer (MO) of Health is a doctor who is the officer in charge of each Medical MOH area across a division which has a community health field staff to carry out the promotive and preventive services and administrative staff (see appendix 5).

TABLE 1: PUBLIC HEALTH MIDWIVES AND PUBLIC HEALTH INSPECTORS AREA IN KALUTARA

(PDHSWP 2006)

MOH area	No. of PHM areas	Average population per PHM area	No. of PHI areas
Bandaragama	27	36 152	6
Bulathsinghala	25	2 660	4
Panadura	55	4 088	13
Honara	39	3 851	8
Mutugama	36	3 089	9
Walallawita	22	2 489	4
Agalawatta	31	2 787	6
Madurawala	23	3 594	5

A MO carries out a number of functions. These include responsibilities for:

- Reproductive health (maternal, infant and child health and family planning)
- Adolescent health
- School health
- Elderly care
- Control of communicable and non-communicable diseases
- Environmental sanitation
- Health education and counselling services
- Food hygiene
- Inspection of building constructions
- Screening services
- Coordination of development projects between the divisional secretariat and the local authorities.
- Inspection of private nursing homes, pharmacies and medical institutions.
- Occupational health
- Disaster management

(PDHSWP 2006)

Doctors undertake a bachelor of medicine and surgery which is offered at a number of universities in the country (see appendix 6). This degree does not incorporate counselling skills for adolescents.

Public health midwives (PHMs)

The PHM is the "front line" health worker for providing domiciliary maternal and child health/family planning (MCH/FP) services in the community, linking it with the health care system. As deliveries are mostly within facilities, PHMs undertake mostly promotive and preventative functions. Each PHM has a well-defined area consisting of a population ranging from 2000-4000.Through home visits midwives provide care to pregnant women, infants and pre-school children. Family planning services include counselling and provision of contraceptive pills and condoms to couples in the reproductive age. PHMs also provide reproductive education and advice to adolescents and motivate all women to attend "Well Woman Clinics" for check-ups. The PHM assists in the delivery of a fortnightly MCH/FP clinic. Midwives are expected to complete a daily return designed to record activities and health issues (Malini de Silva 2011). See appendix 7 for an outline of PHM duties.

Estate midwives

Midwives in the Estate sector, which is largely privatised, provide MCH/FP services to the Estate population with support from the Ministry of Health. They are employed and managed by the Estate company. This is problematic as some estates do not have midwives (CEPA 2005) and they are not necessarily trained under the government system. Many Estate midwives have received a two-year course from a private institution and may be supported by an Estate medical assistant or officer who trained in private hospitals (Logeswary 2007). It has been difficult for the MoH offices to conduct training courses for Estate health workers and to assess their performance as they are not under the Deputy Provincial Director of Health office, but rather the Estate trust (MoHNW/JICA 2003). This may change as a greater commitment is made by the Family Health Bureau to providing standardised MCH services (Fernando, Jayatilleka et al. 2003).

Public health nursing sisters (PHNSs)

The role of the PHNS in the community is exclusively supervisory and does not include the provision of hands-on community nursing. This is problematic as authors (Jayasekara 2006) have noted the mismatch between their training and role has led to a reduced focus on community nursing, which may impact upon the quality of supervision they are able to provide. Despite a presidential inquiry which resulted in a recommendation to establish a 'community nurse' cadre, no progress has been made (Jayasekara 2001). See appendix 8 for a list of duties and responsibilities.

Public health inspectors (PHIs)

PHIs are responsible for disease surveillance, case detection and follow up, environmental risk assessment and implementing control measures at community level. They also distribute contraceptives to women, carry out educational programs and community mobilisation and undertake school inspections. In schools, PHIs undertake a sanitation survey, provide health education, assess food programs and contribute to broader health promotion activities (de Silva 2009). See appendix 9 for an outline of PHI duties.

Education and training of the PHC workforce

There are several education and training routes to becoming a primary health care worker in Sri Lanka. PHIs undertake a one or two-year training course run by the National Institute of Health (NIH). Nurses can complete a three-year Diploma program at one of 11 nursing schools in the country under the supervision of the Ministry of Health. In order for a nurse to

practice as a midwife, she is required to undertake a one-year course at Nursing School as well as an additional six-month course at the NIPH. Alternatively, midwifery status is obtained via the one-year course as part of the Public Health Nursing Sister program which includes an additional six months monitoring and supervision. It has been noted that community and PHC elements in the post basic nursing curriculum require further strengthening (WHO/SEARO 2005).

Another more recent route to nursing is a four-year Bachelor of nursing degree offered by a number of universities in the country. The tertiary route seems set to replace the three-year post basic nursing education (MoH Sri Lanka 2002). Midwifery is regarded by some as being of lower status than nursing (WHO/SEARO 2005). This is problematic and may affect the recruitment and retention of the midwifery workforce in Sri Lanka.

The National Institute of Health Sciences

The National Institute of Health Sciences (NIHS) was established to address all aspects of human resources for health development in Sri Lanka and to advise the Ministry of Health in its policy relating to this. Its key functions are to:

- co-ordinate health manpower development activities in Sri Lanka between the educational and health services agencies;
- initiate and undertake training programs for members of the PHC team with a multidisciplinary approach to training;
- initiate and undertake continuing education of PHC teams;
- conduct research related to health services and manpower development (Piyaseeli 2008).

There are 11 secondary training centres across Sri Lanka that link to the NIH which provide in and pre-service training to PHC workers. Within the training units at the NIH there is no designated unit that looks at adolescent health. ASRH is incorporated as a small module under family health that PHMs, PHIs and PHNSs undertake as part of their training. The Family Health Bureau produced guidelines for health staff in 2006 as part of its School Health Program (FHB 2006) but an evaluation of this is not available.

There are 11 secondary training centres across Sri Lanka that link to the NIH which provide in and pre-service training to PHC workers.

Primary health workforce coverage

There is a shortage of health workers at the PHC level in Sri Lanka. The Health Master Plan provides vacancy rates for selected health personnel in 2001 (table 2). This shows that for all cadres at PHC level vacancy rates are well in excess of 50%. This is greatest in the conflict affected northern provinces where fulfilment rates for public health midwife posts are less than 30% as opposed to over 65% in the eastern provinces. Midwife numbers per 1000 available in the North Eastern District of Jaffna for example are at one per 1000; much less that in the Western Province District of Kalutara which is five per 1000 (MoHNW/JICA 2003).

Special ASRH Health projects

The MoHN has made a number of efforts in the area of ASRH. Youth friendly services were trialled in selected base and general hospitals in the country. Three monthly evaluations of the service found that it increased medical staff levels of motivation to provide these services. Doctors were provided with in-service training in ASRH and counselling, however,

TABLE 2. PRIMARY HEALTH CARE WORKER VACANCY RATES

(MoHNW/JICA 2003)

Category	Medical officers	Nurses	Public health midwives	Public health inspectors	Public health nursing sisters
Revised Cadre	NA	29 286	11 216	2 091	554
Existing No.	6 553	15 844	7 360	1 486	270
Vacancy No.	NA	13 442	3 586	605	284
Vacancy %		**54.1%**	**68%**	**71.1%**	**48.7%**

demand from adolescents was extremely low and the initiative lost momentum. As a result, it is no longer operating. The Ministry of Health has recently developed National Standards and Guidelines for Youth Friendly Services (MoHN/WHO 2008).

The Family Health Bureau has been focusing on the development of a health promoting schools initiative which incorporates ASRH issues using the life skills approach. Some work has been undertaken with the Ministry of Education, however funding problems have affected progress (Lokubalasuriya 2010).

The Family Planning Association (FPA), a NGO which has a long history of providing ASRH services, has experimented with Youth Friendly Health Services (YFHSs) in a youth club setting. This, according to the Executive Director, has failed to generate demand for health services (Wanasekara 2010). The FPA provides regular training to update the skills and knowledge of its staff. Youth access to and knowledge of available services has been found to be low (Agampodi 2008; SEARO 2008). However, some strategies to increase attendance have been identified including an ASRH counsellor training initiative. This led to an increase in the number of adolescents attending FPA clinics (Basnayake 1993).

UNFPA has also piloted YFHSs with different partners. A service was offered in Kandy with the NGO, Sri Lanka Association for Voluntary Surgical Contraception and Family Health. This was terminated as an evaluation showed that the number of young people coming in for ASRH services was less than two per cent of the total number of visitors. A pilot in Anuradhapura with the National Youth Services Council was planned but never implemented and another pilot with NIHS was shifted to another location based on a circular issued by the Ministry of Health asking all MoH offices to have a youth centre (Chawla 2011).

Secondary Education in Sri Lanka

The Ministry of Human Resources Development, Education and Cultural Affairs (MoHRD E&CA) in Sri Lanka is responsible for education in the country and has two non-cabinet level ministries. These are the:

- Ministry of Tertiary Education and Training – for universities and technical colleges.
- Ministry of School Education – for schools, pirivenas (monastic colleges for the education of Buddhist priests), teachers training colleges and colleges of education.

There are five divisions under the MoHRD E&CA with the secretary of Human Resources Development of Education

Enrolments in schools are increasing in Sri Lanka as **participation in the labour force for 15-19 years is declining.**

Services division playing the main role in HR issues. The Education Quality Development division includes groups concerned with special areas such as guidance counselling and co-curricular activities, science technology health and technical education. In addition there is a separate group under this division that deals with teacher education.

The education management structure in Sri Lanka was decentralised in 1987 and facilitates the autonomy and participation of local administrative bodies in education decision making processes. This decentralised management organisation structure comprises five inter-linked layers that are outlined in Figure 2. The MoHRD E&CA is the Line Ministry under which the Provincial Ministries and Departments of Education sit, followed by the Zonal Education Offices, the Divisional Education Offices and finally schools (Provincial and National).

At the provincial level, under the Provincial Director of Education, there is a HR development deputy director as well as a second additional provincial director who is assigned to oversee teacher supervision, guidance counselling and in-service training systems.

Structure of the school system

Education institutions can be categorised into three groups: compulsory basic education; college level; and tertiary level (table 3).

The education system is comprised of government schools (national and provincial), pirivenas and private schools (non-fee-levying or assisted fee-levying autonomous and international schools). Enrolments in schools are increasing in Sri Lanka as participation in the labour force for 15-19 years is declining (PRB 2006). As a result, secondary teachers are facing an increasing demand for education including ASRH information.

ASRH in the school curriculum

There are three subjects (Life Competencies and Citizenship Education, Health and Physical Education and Science) in

FIGURE 2. STRUCTURE OF EDUCATION IN SRI LANKA

(MoE 2007)

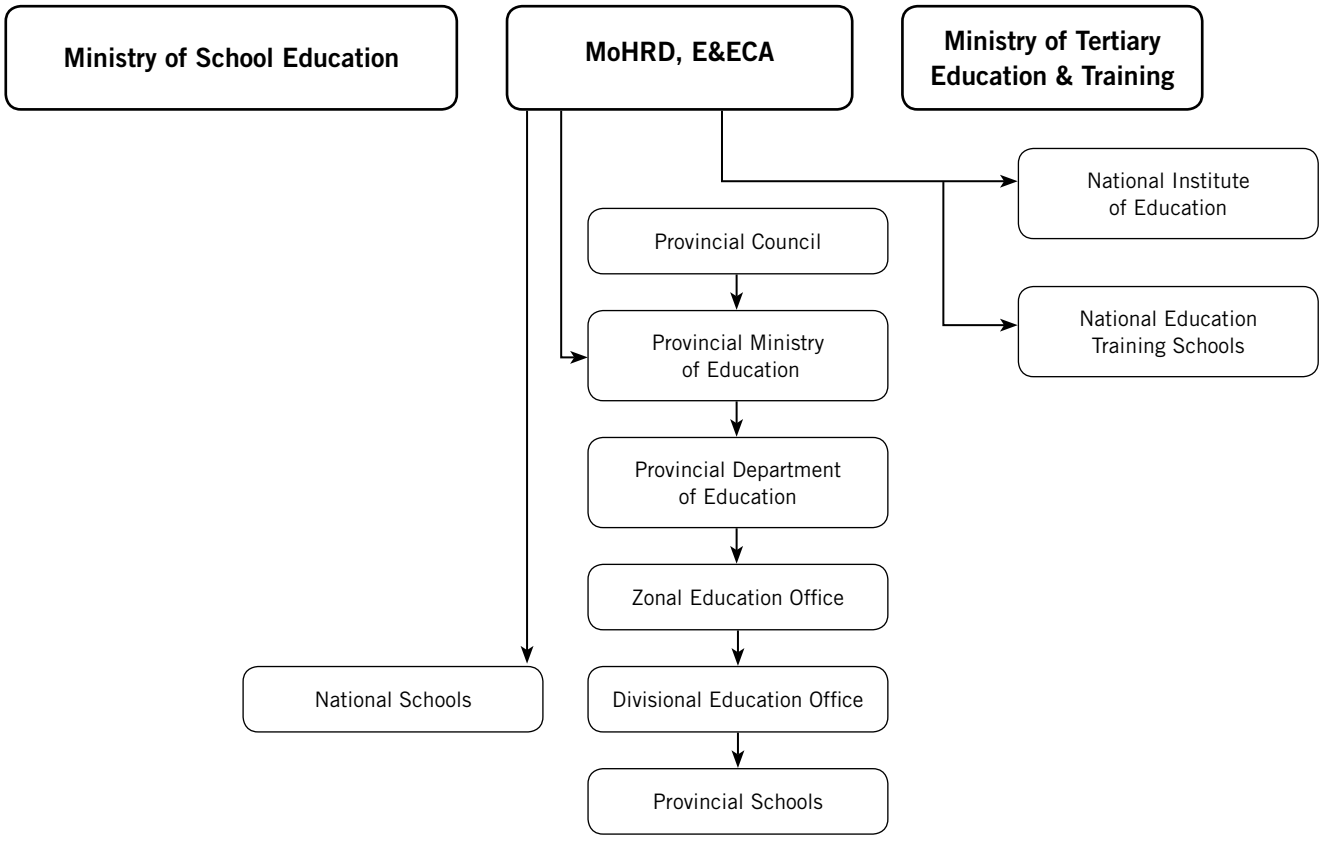


TABLE 3. EDUCATION INSTITUTIONS IN SRI LANKA

(NIE 2005)

Level	Grade	Age range (years)
Compulsory Basic Education		
Primary School	1–5	5–9/10
Junior Secondary School	6, 7, 8	10/11–12/13
Senior Secondary School	9,10, 11	13/14–15/16
General Certificate of Education Examination		
College Level		
Pre-University Stage	12 & 13	16/17–18
Technical College		
Tertiary level	University and National Colleges of Education	

TABLE 4. EXAMPLE OF RELEVANT ASRH CONTENT AND COMPETENCIES IN THE SRI LANKAN SCHOOL CURRICULUM

SUBJECT	GRADE OFFERED WHERE CONTENT IS RELEVANT	EXAMPLE OF RELEVANT CONTENT AND COMPETENCIES
Life Competencies and Citizenship Education	6 and 8	**Grade 6 example** 3.2 Building up healthy relationships through effective communication 6.2.6 People who help us Grama Nilandari, Samurdhi officer, police officer, midwife, public health officer (NIE 2006)
Health and Physical Education	6-11	**Grade 7 example** ***Competency 9:*** Chart of reproductive system to be included although not included in systems in (NIE 2007) "smoking is the main cause for sexual incompatibility" (p 181) ***Competency 11:*** Facing Challenges successfully for the Wellbeing. Includes "disease caused by touch, infected blood and unprotected sex" HIV, Hepatitis B, gonorrhea, syphilis symptoms and prevention ***Competency 13:*** Leads a happy life, successfully facing obstacles on day life. Abuse and exploitation included and a suggestive case study inferring the rape and murder of a girl and encouraging children to seek help & prevent vulnerability
Science	6, 7, 11, 12, 13	**Grade 11 Biology example** ***Competency 2:*** Investigates on the reproduction of organisms 2.3 reproduction in human – structure and function of the reproductive system, sexually transmitted diseases i.e. HIV, syphilis and gonorrhoea (NIE 2008)

the school curriculum offering content and competencies that are related to ASRH. The curriculum of grades 6-13 was examined for this. The findings of this content analysis are summarised above (table 4) indicating the grades each subject is taught in, alongside relevant examples of content or competencies. A more comprehensive table of findings is offered in appendix 10.

Health and Physical Education is the key subject in which material related to ASRH can be found. This subject includes content on: child protection, building relationships with others, appropriate behaviour, maintaining health and preventing disease and growth and development. This subject can be taken as an ordinary level unit in the General Certificate Education (GCE) and has a high pass rate. However, it is not recognised as a subject at GCE (Advanced Level), hence is not a subject for university admission (Amunugama 2008). This does not appear to be in line with recent moves to develop tertiary studies in nursing and other allied health professions thereby missing opportunities to promote careers in PHC.

Confusion between the content of Health and Physical Education and the subject Life Competencies and Citizenship Education has been reported (Amunugama 2008), as well as problems with the inappropriate teaching and learning methodologies and untrained teachers (UNICEF 2004). Course objectives for grade 6-11 general science, and more specifically biology in higher grades, include developing the competencies related to the human reproductive system but contraception is not included in this content.

The teaching of reproductive health content has been found to be held back by the negative attitudes of some teachers and principals who felt it would promote promiscuous behaviour. Moreover the number of sessions dedicated to health is reportedly inadequate (de Silva 2009). An evaluation of reproductive health education revealed that 58% of students were dissatisfied with the reproductive

An evaluation of reproductive health education revealed that **58% of students were dissatisfied with the reproductive health education they received.**

health education they received. Only 2.5% of these students reported that teachers were their preferred source of reproductive health information. Most teachers also perceived their knowledge and teaching skills regarding reproductive health education as inadequate (Senaratne 2003) and felt uncomfortable teaching this content (UNAIDS 2009). In addition, a UNICEF study found that less than 25% of school children had read a number of sexual and reproductive health (SRH) books designed for them mainly due to poor distribution (UNICEF 2004).

Current Special ASRH education projects

There are a number of current projects involving teachers and school students that warrant attention. A Psycho Social Intervention Project was implemented by the Ministry of Education with UNICEF funding in 2005 with the aim of integrating HIV/AIDS information into the life skills curriculum. This was enhanced with a Round 6 of Global Fund money in 2008 and 2285 teachers in 698 schools were trained from selected provinces (UNAIDS 2009) to implement the HIV/AIDS curriculum and deliver counselling to students. The approach taken is a cascade training model at zonal level with an in-service-adviser in counselling in each zone that trains 6 trainees using 2 manuals and appoints a senior trainer of trainees. This team is responsible for providing teachers, as selected by school principals, in their zone with awareness training (Amarasinghe 2010). This project has been further enlarged through an Education for Knowledge Special Project funded by a loan from the Asian Development Bank (ADB). As part of this the MoE is developing materials such as board games (MoE 2007).

A large Sexual and Reproductive Health Information, Education, Counselling and Services to Adolescents and Youths program, co-ordinated by UNFPA and NGOs under European Commission (EU) funding, was implemented between 1998 and 2002 (UNFPA RHIYA Central Unit 2003). Two hundred counselling service points were developed under this initiative. Sixty percent of those trained were school teachers who established service points at their schools.

The evaluation report of this project states that teachers, who had been trained under the MoE program and who had become disillusioned with counselling youth due to a lack of a supportive environment, gained motivation through the UNFPA initiative.

Overview of the secondary school education workforce in Sri Lanka

Teacher training

There are 17 national colleges of education that have been established to give pre-service training to all teachers to be recruited. In addition there are four university faculties/departments of education, and four teacher education institutes providing continuing education which is offered through a network of 100 teachers centres (NARIC 2007).

Senior secondary teachers are required to have completed a Bachelor of Arts in education, a four-year degree, or have a three-year Bachelor of Arts or Science degree combined with a postgraduate Diploma in education, totalling four years of study. Lower secondary teachers are required to have a three-year secondary education certificate from the National Institute of Education (NIE) plus one year of practical experience.

National Institute of Education

The NIE was established to undertake several functions including:

- Advise the Minister regarding plans, programs and activities for the development of education in Sri Lanka.
- Provide and promote postgraduate education in the several specialties of education.
- Conduct and promote studies on the education system including its performance, goals, structures.
- Initiate and promote innovative practices in the education system.
- Provide for the development of professional and general competence of personnel in the education system.
- Carry out education development programs.

(NIE 2005)

The Institute offers courses including Masters of Education, Certificates in Teaching for teachers and courses with special focus in areas such as mathematics, technology and special education; however none appear to be in the health or counselling area. In addition there are no ASRH programs under the 2010 scheduled teacher training programs for teachers teaching GCE. The National Education Action Plan

There are reports of negative teacher attitudes towards the provision of ASRH information, with **some teachers expressing the opinion that it may exacerbate promiscuous behaviour.**

recognises that there is a gap in the provision of counselling and career guidance for students and notes that selected teachers will be trained in this area (MoHRDECA 2006). Training for teachers in counselling is being offered at zonal level under a Psycho Social Intervention Project described above.

There are four key subjects, including science and health and physical education, that come under the Faculty of Science and Technology, while guidance and counselling and teacher training come under the Faculty of Education Leadership Development and Teacher Education. Health is a core subject compulsory for every trainee to study and is not recognised as an area of specialisation. Most teachers who engage in teaching of health are not those trained for the purpose (Amunugama 2008).

Summary

A desk review of ASRH programs and health and education providers in Sri Lanka has highlighted a number of issues that are summarised below.

Provider roles in ASRH

- Primary health care workers and teachers play important roles in the provision of ASRH, but their roles appear to be broad and not clearly defined.
- There is a paucity of information regarding mechanisms to support the collaboration of health and education providers.

Provider education and training

- There is no specialised ASRH or counselling training for teachers at national level. A number of programs have been launched but are not operational in all provinces
- There is a new program that offers counselling training at zonal level in some areas but no evaluation is yet available.
- There is little available information on continuing education for health providers in ASRH.

Provider ASRH practice

- Teachers regard their ASRH teaching skills as poor and evaluations indicate inappropriate teaching and learning approaches.

Provider attitudes

- There are reports of negative teacher attitudes towards the provision of ASRH information, with some teachers expressing the opinion that it may exacerbate promiscuous behaviour. Other teachers have stated that ASRH information provision is not necessary as ASRH problems do not exist or are very minor.

Health education

- ASRH information is incorporated across three subjects from grade 6 to 13. Contraception is not included in the school curriculum.
- Health is not available as an advanced health subject on its own and there is a lack of promotion of careers in health to school students.
- Evaluations report that there is a lack of time dedicated to health in the school curriculum

Health promotion

- Health materials are not being accessed by students

FINDINGS: PROVIDER INTERVIEWS AND SURVEY OF ASRH KNOWLEDGE, ATTITUDES AND PRACTICES

Participant characteristics

Table 5 (page 20) provides a summary of the 65 providers who indicated their interest in participating in this study. Similar numbers of male and female education providers were interviewed. However, there were considerably more female health workers due to the fact that the Sri Lankan nursing and midwifery profession is largely comprised of women. Smaller numbers of early career professionals were interviewed with the majority in the middle and later years of their careers. The majority of the participants were Buddhists which reflects the dominant religion in the country.

Current state of ASRH services, programs policy in Sri Lanka: issues and needs

Perceived adolescent issues and needs in the context of the family and society

Providers were first asked to share what they regarded as significant SRH issues for Sri Lankan youth and what they felt adolescents required in order to address these issues. Their discussion also involved a description of how they perceived the family environment of adolescents and how this and the socio-cultural context impacted upon adolescent behaviour.

The respondents highlighted particular issues that they perceived to be significant for Sri Lankan adolescents that required attention. ASRH knowledge gaps were noted in the area of sexually transmitted infections (STIs) and abortion through KAP surveys and in discussions. Statements were made regarding the need to provide family planning information to adolescents, as well as raise awareness of the reproductive health system and physical changes during puberty. Love affairs were seen as problematic by providers because they had the potential to distract students from their studies, result in teen pregnancy and lay girls open to abuse particularly from relationships with older men. Teachers gave many examples of attempts to dissuade girls to stop affairs which involved interactions with parents. Other issues mentioned were sexual harassment and the need to raise awareness so that girls were able to seek help.

Other than the provision of information, health workers and teachers felt that adolescents should have good access to caring and qualified people. In the focus group of Estate midwives one respondent said: "There should be someone whom they can talk to in their level, if they are having any problem at present". However, access was sometimes difficult: "Most of the time, youth don't know even where the counsellors are." (PHNS) Other PHNSs commented about the need to increase counsellor numbers. Pre-marriage counselling was regarded as helpful to provide adolescents with information about sexuality and reproduction.

Health workers and teachers also referred to issues around sexual abuse. They indicated that this was not only a problem for both male and female adolescents but that it was vital to raise awareness so that teenagers could identify that this was not appropriate behaviour and seek help.

Providers linked this abuse to dysfunctional family contexts. Some of these were characterised by a lack of parental love:

> *They don't properly receive that love of parents. So then they go in search of another love. They may do unnecessary sexual activities as well.* (PHM)

Poor living conditions were also linked to abuse:

> *Another thing is that there are children who have experienced behaviours of the parents and living in small houses. I know several cases like that. Incidents where children got raped sometimes by relations.* (Male teachers)

And some providers stated that exposure may actually lead adolescents to seek further sexual contact:

> *She got raped by an army soldier. So she continued going in search of pleasure. Finally she became pregnant.* (Male teachers)

Many participants commented on the lack of support many teenagers had at home which often stemmed from their financial situation:

> *On the other hand economic problem affects these issues very much, such as mothers going abroad. Mothers go abroad, fathers loitering drunk. There is no one to take care of the children. In a situation like this, mostly girls become helpless.* (Estate midwives)

According to providers this family situation is often associated with sub-standard parenting as evidenced by the poor supervision of children and the lack of emotional support.

As a result, children do not always receive information about SRH from their parents. This can stem from poor knowledge and attitudes of parents:

> *Due to unawareness, if not due to less education of the adults they call these things as teaching filth.* (Estate midwives)

TABLE 5. PARTICIPANT CHARACTERISTICS

CADRE	NUMBER	M	F	<35YR	35-45	>46	BUDDHIST	CATHOLIC	MUSLIM	HINDU
Education provider										
Female teachers	7	7								
Male teachers	7		7							
Teacher – counsellors	7	3	4							
School Principals	6	3	3							
TOTAL	**27**	**13**	**14**	**7**	**10**	**10**	**22**	**2**	**1**	**2**
Health Provider										
Public health inspectors	7	7								
Public health midwives	10		10							
Estate midwives	7		7							
Public health nursing sister	8		8							
Medical officers	7	4	3							
TOTAL	**38**	**10**	**28**	**5**	**16**	**17**	**31**	**2**	**1**	**4**
	65	23	42	12	26	27	58	5	2	

In addition, the lack of parent knowledge and poor attitudes affects the ability of providers to deliver ASRH information to adolescents:

> *Parents, who are not knowledgeable, hardly convey that knowledge after going home. They think that it is a disgrace for them. That is an obstacle which we have.* (PHM)

Adolescent problems were said to be regularly ignored at home: "Parents don't like to accept, how much ever we identify such risks involved on a particular child." (PHNS) Providers stated that parents often ignored their advice: "Parents may challenge us saying our children are not like that."

This, providers felt, was related to the belief of many parents that their children are too young to receive SRH information, or that educating children will negatively affect their behaviour: "Some parents don't like to teach these to their children, because they think that their obedient child may deteriorate." (PHIs) Other parents, according to providers, do not feel that SRH information is necessary until their children are married:

> *Actually in according to the culture in Sri Lanka, sexual relationship is allowed only after entering in to marriage life. So sometimes parents think that providing knowledge on family planning equipment, how to use those equipment etc. for the adolescents is something unnecessary.* (PHM)

In the interviews providers spoke about the socio-cultural values that informed parents' attitudes towards child marriage:

> *Parents say that they have to allow the girl to marry if a man asks for that particular girl. If the man is agreed to that girl, and if he is asking, then mothers have to give the consent for their marriage. If not, or if they delay, the demand for that girl, to marry her will decrease. There are problems like that.* (MOs)

Providers tried to dissuade parents: "I explained her that it is not (14 years) a suitable age to get married." (PHNS) Child marriage, according to one provider, could result in suicide. Respondents mentioned the need for adolescents to be informed of the risks related to early child bearing

but these discussions were not in relation to child marriage but rather teen pregnancy outside of marriage. The social consequences of this were mentioned several times by participants: "Especially if the girls get pregnant without marrying, they blemish their image in the society, if they give birth to fatherless children. We have to explain on things like that." (PHNS) Adolescent pregnancy outside of marriage was seen to be perpetuated through the generations:

> *The tendency of teenage pregnancy and teenage marriages are higher when the teenagers are coming from similar backgrounds (where mother and father experienced teenage pregnancy). I think these kinds of things come from the family.* (MOs)

This cycle of teenage pregnancy, providers believed, was accompanied by poverty at home and a dysfunctional family environment which affected the ability of teenagers to participate in school which, in turn, put them at risk of pregnancy:

> *One thing is that, I think children must be made aware of incidences where people destroy their lives due to inappropriate sexual behaviour. Actually children do these due to ignorance. For example, there were parents who were 25 years of age and having 4 children. They got married at the age of 14. The three children who are students of the school were absent. So I investigated and got to know that those children were not provided with food. No food to eat. Not even provided their dinner on that very day. Those parents didn't have the capacity. No financial capacity. Man got drunk and didn't go to work on that day. So the main reason is getting married at an unnecessary age, at the age of 14. So at the age of 25, they were having 4 children. No way to live.*
> (Male teachers)

Many providers identified a great need for parent education and empowerment so that parents can provide accurate and appropriate information to their own children and participate in health programs. In the FGD of the MOs one participant described the important role that the mother had in supplying SRH information to adolescents.

This they said was based upon their own investigations that involved asking teenagers who they would like to best receive information from: "more than 90% of the answers (from the students) were from mother. So the choice of the children was the mother. So the mother has a very important role to play."

In addition providers saw a need for quality sexual and reproductive health services for parents which would work to reduce the burden on children:

Respondents mentioned the **need for adolescents to be informed of the risks related to early child bearing** but these discussions were not in relation to child marriage but rather teen pregnancy outside of marriage.

> *I think it is also good to give counselling for parents to avoid sexual impairment. If not, the child will get into that condition at that age. Have to work to protect (the child) from it.* (Male teachers)

According to some respondents, improving the bond between parents and children is central to the provision of ASRH information. This was also related to changes in society and parent roles which have resulted in a greater openness to delivering SRH information:

> *I had that closeness with my parents. If all the parents can come to that level, but it might be difficult to older parents (who are from the previous era). I will be able to inform this to my children as my mother was able to do that to me.* (MOs)

The rapid changes in Sri Lankan society were noted in relation to adolescents being able to access large amounts of information on the web. Providers felt that they needed to prepare a plan to deal with questions that might arise from the searching of material, particularly material of a sexual nature. This situation was of great concern as it was felt that family and cultural values might be challenged. Many respondents believed that values and norms must be promulgated by the family:

> *We have to emphasis all the time to our children, even though the sexuality is common to all of us, that we must protect the unit of family. I think if we make the child aware on our culture, norms and values, it will avoid rising of the unnecessary questions.* (Male teachers)

Providers – mostly male teachers – were also concerned that there was a danger that the information and values promoted through an open society would negatively impact upon adolescent sexual and reproductive behaviour:

> *Then the students go to the open society. Society is the main cause of teenage problems. The social environment*

is mostly responsible for the way a child is being developed. (Male teachers)

Providers, however, discussed possible negative consequences of the lack of openness in Sri Lankan society. These included the reticence of adolescents to access condoms and the potential to encourage inappropriate behaviour as "the curiosity of the children increases" (MOs). Suicide was noted as an extreme result of a student's fear of being found with reportedly explicit images:

A school girl hanged herself using a tie. It was also due to a small issue like this, some pornographic pictures were in her mobile phone. But due to investigating it she got into such a position. (Male teachers)

Respondents saw a clash between the openness of Western culture and the Sri Lankan culture where SRH issues are "discussed under cover" (MOs).

Media and ASRH

The media emerged as an important area of concern in the focus group discussions and key informant interviews despite being unprompted through questioning. This highlighted the importance that providers attached to the mass media and information technology as a tool for disseminating ASRH information and influencing the behaviour of young people in Sri Lanka.

The discussion in the focus groups of PHIs and PHMs indicates that these providers perceived adolescents as receiving their SRH information from a variety of sources including the mass media, videos, DVDs and the internet. In addition: "They acquire it by sharing knowledge among peers or among friends." (PHIs) Providers felt that young people were highly skilled in the use of information technology, particularly the internet and mobile phones, whereas they saw themselves as lagging behind in information literacy skills and needed training as well as improved access at work.

According to providers, adolescents have access to inappropriate information at too young an age. This included material on the television and on film. One male teacher describes a recent experience where students viewed films that contain sexual scenes, and voices concern about the impact having knowledge of sex at ages 13 and 14 will have:

I found out a group of students in year 9. I got even the information of the leader. More than 80% of the male students in the class have seen them. There is a place nearby, where these could be purchased for Rs 20/- or Rs 30/-. Students are having more opportunities. When I go the level of the students, I found out, they fully aware of this procedure, even though they don't practice. They have acquired full knowledge on how the sexual process is performed. So, their minds have spoiled. Then the only thing which can be seen from them is a tendency of pulling out of education. So, spoiling of their minds is the biggest damage occurred to them. (Male teachers)

A number of providers felt that the media is very persuasive and encourages children to carry out inappropriate behaviour. A PHM states that watching movies can lead students to "try to experiment with it. Sometimes it may be with the girl next door. Sometimes, they may hide and watch while a girl is bathing." Another midwife says:

The television it also affects a lot. From 6.30 pm to 10.30 pm all what the children see, through the television are things which arouse sexuality. I think it has become a huge social issue. Because this affects the education of the child as well as other things. I think it is more dangerous to show half naked pictures than showing nudity. It will create the curiosity to see the other parts.

Teachers felt that some students had become "addicted to watching blue films" (teacher counsellor 8) which had not only led to a group of students regularly missing school but other behaviour including uploading pictures of naked girls:

They try to experiment many things through the camera phone. They first watch it from the phone and then try to experiment. Very recently there was an incident where the child has captured the sexual activities of the parents from a camera phone through the keyhole and got caught to the police with the phone. That means they use the technology for wrong purposes. (PHMs)

The media is described as a destructive force: "Other thing is the external forces, such as media business. They are keeping their eyes open to destroy youth like demons." (PHNS) The effect is seen as serious and long term. One male teacher describes the effect on one boy of seeing "blue films at home". "He was exposed to these regularly. After that he didn't come to school. He was spoiled. We couldn't rescue him." However it is not just what providers appear to regard as pornographic material that is inappropriate viewing, standard TV material is also problematic as it can distract students:

Students fill their heads with the tele-dramas which are telecasting in the television, which gathers the whole family to one place; then the students cannot memorise

According to providers, adolescents have access to inappropriate information at too young an age. This included material on the television and on film.

the lessons. That is another problem. Students follow the characters in the tele-dramas and they bring the problems of the characters to the classroom and discuss. (Teacher counsellor 8)

Much of the problem, according to the respondents, is that the media normalises behaviour that may not be acceptable. Examples of this are teen sex and wearing miniskirts on tele-dramas. Complaints were also made about the way in which media portrayals did not provide cues to positive action to resolve difficult problems. "They don't show on solving the conflict in a constructive manner even at the end. The drama proceeds in a destructive manner." (PHI)

Even the press gives less attention to these. They report daily on incidences such as attacking, killing, sexual harassments etc. But no reporting is done on the cases where people solve their problems through counselling. So, most people think that there is no such a service. (PHI)

Providers did not believe that the media always presented a balanced view of behaviour or reality. One midwife said: "There are more adverse things when compared to good things which are conveyed through media." And a male teacher noted: "Actually all the scenes in the CDs are abnormal. So the children think that this is the reality." In addition respondents did not feel that the media presented appropriate role models:

Then, very recently I saw a famous actress in a TV program says that we have to get married but if we can't continue then go for the divorce. She openly made that statement without any problem. But it is being watched by so many adolescents. Specially, children in year 10, 11, 12 classes grasp that. She is a famous actress, an important person in the society. So we must take these statements in to consideration. There are so many problems like this. If we can provide solution to these, we might even be able to minimise them. (Male teachers)

Media portrayals were also said to be disrespectful to Sri Lankan culture:

We have eastern culture in our country. When we think of our culture, we disagree with nudity …. even though it is shown in films or TV. We completely reject nudity. When these kinds of scenes are shown over and over again, it might develop an idea that this culture is being destroyed. (Male teachers)

Despite this, participants saw the value of using the media to disseminate ASRH information and promote responsible behaviour. A female teacher gave an example from a film:

If I go to our past, there was a film named "Ransalu". In that when Toni Ranasinghe (the main actor) touches the hand of Punya Heendeniya (the main actress) inside the car, she says, "Don't, we are still not married, don't come to that level." So the child learn something from it. Learn something on living simply. (Female teachers)

Social marketing using media was regarded as having merit, such as messages for youth on stickers on buses and using advertising approaches:

Now, cigarette companies say they need only a pair of lips to increase smoking. If we can present something like that, through media, related to reproductive health. This is how it becomes important. (PHIs)

Interestingly, participants regarded media policy as the way forward in terms of regulating the portrayal of sex and sexuality: "Making a standard on ethics of media is a must." (Male teacher)

Other than that I think a huge amount of work can be done through media. If the mass media is having a proper policy and a guide, we can convey a bigger message ….that will give a bigger effect to the current society. (MOs)

ASRH policy environment

Government policies help guide provider practice and support the planning, implementation and evaluation of programs and services. The participants discussed policy needs and priorities throughout the focus group discussions and key informant interviews.

A number of policy areas were identified by the participants. PHNSs were vocal in their opinions regarding the need for a policy focus on girls. They hold the opinion that the "government is paying less attention to girls. They give more attention on infants, pregnant mothers but not on girls", the

outcome of which means that decisions makers "allocate lesser funds and lesser facilities". More broadly, providers recommended the need for a policy to raise the profile of all young people, as well as a policy that renders ASRH education as culturally appropriate and targeted.

One PHNS called for the policy and legislation related to the age of marriage to be lowered to 16, in line with the age of sexual consent, as adolescents are already having sex and hence need to be married. In addition: "They may even commit suicide because this situation is not prevailing, especially girls." This is in stark contrast to other health workers and providers who highlighted the dangers of early childbearing and problems with early marriage. These providers cited education as a key need in this area rather than changing policy and legislation.

Providers spoke of the need to make policy inter-sectoral, involving "people in every field and every level" (PHNS). MOs stated that:

> *I think there has to be a policy decision on sexual education. Now we have a problem on whether we are providing the sexual education properly. Educational Ministry and Health Ministry have to get together and must take a good policy decision. These two sectors have to get together to do this in a better way. I think we still don't have a proper decision on this.*

Bringing Ministries together for policy making was seen as a priority requiring a master plan which will bring staff from the health and education sectors together: "We can achieve results in the future only if we start them today." (MOs).

Providers saw a particular need for media and IT policies that restricted access to inappropriate materials that were sexual in nature. One MO recounted an experience at an internet café:

> *There are so many places where knowledge can be acquired. So children receive this knowledge somehow more than we imagine. They acquire knowledge informally. So we need to have some kind of proper policy to formalise. The best example for this is I went to an internet café because my computer was not working. There was a school boy next to me, I just sneak a quick look, all what he was doing was accessing pornographic websites.* (MOs)

Some respondents felt very strongly about the need for policy stating: "Media contributes for more than 50% of all the problems in the society." (Males teachers) This, according to one school principal, required "controlling the programs

One PHNS called for the policy and legislation related to the age of marriage to be lowered to 16, in line with the age of sexual consent, as adolescents are already having sex and hence need to be married.

of the various media institutions (television, radio, phone) which are distorting the minds sexually, of the children, and maintaining a proper system of ethics on them". (Principal 5) Laws and policy were seen as important alongside appropriate sexual education:

> *If we can provide sexual education properly, then there is a higher possibility of hindering these unwanted programs which are showing up of nudity. All the proper programs must be done only with the involvement of state institutions.* (Male teachers)

ASRH services and information delivery

ASRH programs and services provided through the health sector

The health and education professionals interviewed were asked what their perceptions were of the sexual and reproductive health programs and services that were, or had been, provided for adolescents.

A number of comments were made by the health providers about either the lack of program: "In Sri Lanka specifically related to reproductive health – there is no such a thing" (PHNS) or the limited, sporadic nature of ASRH programs:

> *Very limited. Services which are being provided are minimal. If we take our batch (batch of medical college graduates) as an example, services which are rendered for adolescents through public health sector is very less. There is some ad hoc work which are there, but without much organising. .... medical services which are specified for adolescents or counselling services for them are very rare in our society. Sometimes doctors provide these services up to some extent, but there is a limit even in it.* (MOs)

Examples of short term ASRH initiatives were given that lacked not only ongoing funding commitment, but were not comprehensive in their reach. One such example was the

Youth Friendly Service Centres which were described as "only a project" by the MOs who bemoaned the fact that they had no support to continue the service and, as a result, were no longer functional. Problems with the evaluation of these services was raised, which either did not take place or used inappropriate indicators for assessing outcomes:

> *There is also a problem regarding the datum for measuring, because when we provide counselling there will be a qualitative development but quantitatively it seems very small. That is regarding the service.* (PHIs)

This, according to the providers, results in a lack of integrated long term planning: "Nothing happens methodically or systematically." (MOs)

Funding issues were regarded as the core problem, particularly on the Estates:

> *Now days we don't receive much funds. Because, there is a story that we will be absorbed to the government. Earlier, money was granted from the Trust to do these kind of programs. But they have reduced it now. Don't know whether they may not have money by now.* (Estate midwives)

The privatisation of the Estate sector was seen to have affected how money is spent on health with decisions on health spending made by the Estate superintendent:

> *That means the attitude of the estate superintendent has a huge effect on these. Now, in some estates, less attention is paid to the health of the employees. They are only chasing after profits. They think that this is only an expenditure.* (Estate midwives)

Financial problems meant that programs were dependant on voluntary contributions from communities and organisations such as the National Workers Union.

Despite a number of issues with programs, respondents discussed a range of initiatives that they regarded as having merit. These ranged from grass roots health promotion programs in villages and services in camps for internally displaced people, to the YFSC and services previously provided in hospitals. In terms of the YFSC it was noted as being "a good example" (PHNS) and one PHI stated:

> *I think most of youth who have finished their schooling gathered there after implementing the center. It is good, if we can propagate things like that more. That is the only place for the entire MOH. It is better if we can propagate more, on the basis of areas by acquiring the involvement of more people than this.*

However, providers noted that the YFSC in their district was the only one currently functioning in the country and this needed to be scaled up:

> *We would be able to do a significant amount of work if such a service is there in every MOH or if there is a doctor specially meant for this, there should be someone who is related to this. It is good if the level in Beruwala is there also in other parts.* (MOs)

A number of respondents suggested that separate services for youth was useful in terms of improving access for adolescents to health services and to overcome social and cultural barriers:

> *It is better if we can discuss these separately in situations like STI or unwanted pregnancy without going through the general stream. It is difficult for an adolescent to go to a clinic in a hospital (because it is not the practice). There should be a separate medical service.* (MOs)

This perceived need was not met through various experiences of adolescent service demand, which was much lower than expected for the services provided within hospitals as well as the youth friendly centres. A lack of teenage awareness of the services offered was one reason cited for the lack of demand:

> *Another thing is that children are not aware that they can acquire knowledge from the health staff. That means some adolescents don't know that they can acquire knowledge from PHI, medical office, public health midwife etc. Rarely an adolescent comes to them searching for knowledge. That information has to be made known among adolescents.* (PHMs)

Providers felt that adolescents actually receive most of their SRH information from their peers: "Mostly adolescents share these with friends. They take advices from their friends. Who are in the same age groups, peer groups." (PHMs)

Another issue was that although the Youth Friendly Service Centre provided facilities for out of school youth, the majority of adolescents needing and using the service are still in school "and it therefore does not serve their needs which should be offered at school. What I am saying is these services must be provided through school." (MOs)

Timing issues associated with the delivery of services were discussed. This related to the fact that adolescents are mostly

Not only did some participants feel that ASRH education should be better aligned with culture, but also **integrated across "science and technology, citizen education, health and physical education".**

in school, therefore programs needed to be provided in the evenings. However, this clashed with the working hours of providers and, in addition, many school students had after school jobs:

> *It is difficult to say, whether people will come even if we conduct programs after 4 pm. Because, soon after leaving school, most of the adolescents go to work in garment factories.* (PHMs)

A number of health education materials were highlighted as having specific use, in particular was a series of material called "The Dawning of Youth" which was published by the Ministry of Health. However, it was not widely supported: "Principals objected to include that book to the school libraries." (PHI) However, students reportedly found the material helpful: "We gave it to students. They read it willingly; they liked to read that book very much." (Female teachers)

ASRH programs and services provided through the education sector

In addition to discussing services offered through the health sector, participants made many comments about their perception of ASRH services offered through the education sector. This included not only the information provided through the school curriculum, but also through special ASRH programs and through the counseling services offered by teachers.

ASRH in the School Curriculum

Respondents reported that ASRH appears throughout the school curriculum across the "science and health and physical education subjects" (Principal 6). There were a number of options regarding its quality and amount of focus. Some teachers regarded the SRH content as "very good" (female teachers) while one Principal describing it as "not sufficient" (Principal 2), and a MO felt that "It doesn't cover the topic comprehensively." Content gaps were noted "on mental health or on sexuality" (female teachers). However, this contrasted with the sentiments of the male teachers who felt that there was too much focus on sexuality in education: "It is there in the syllabus, to some extent. Now what I feel on this is that we are trying artificially to load sexual education. There is something like that. I feel that this is too much." In addition, male teachers felt that NGOs added to this through their programming:

> *Now it is being loaded by force. We don't need to go further. We must make a methodology in the syllabus for the child to absorb this effortlessly. It has to be developed (the syllabus).* (Male teachers)

An over emphasis on the anatomical and physiological aspects of reproduction rather than emotional and social factors was noted, which was regarded as too technical and not always useful: "When we take an exam paper, when we consider the things which are being asked, even I, who has a science degree can't answer them." (Female teachers)

Providers also noted that because the ASRH content was not in a dedicated health subject there is not a "proper long term program" (Male teachers). This indicates that the material is taught in short bursts rather than in an integrated and continuous manner.

Providers pointed out that the staggered nature of this education meant that information was not always provided at salient points or when required by students. This, according to providers, had an effect on the demand for personal counselling and information provision and increased the need for individual consultation and thereby their workload: "That means, when we came across a problem of a student, the teacher takes him/her separately and discuss." (Male teachers)

The need for a consistent delivery approach, as noted by male teachers above, was seen as important by other providers in relation to the socio-cultural context of Sri Lanka. Female teachers and Principals discussed the need to connect science and religion subjects in order to improve ASRH education:

> *Sexuality can be taught with much more control and discipline through Buddhism, unlike in Western methodologies. This avoids creating curiosity in the child and also avoids looking at the society in wrong attitudes.* (Principal 3)

Not only did some participants feel that ASRH education should be better aligned with culture, but also integrated across "science and technology, citizen education, health

and physical education" (Principal 5). Other respondents stated: "My idea is, it is better to give the primary knowledge separately and then put together when they have understood and to provide the other part." (Female teachers)

The need to separate the teaching of ASRH education was seen by some as the result of embarrassment among students which translated into nervous laughter and ridicule:

> *But there are times that they can't raise questions; even though they have that curiosity, due to the possibility of becoming a joke especially among boys. So I would suggest it is better to conduct programs on these by using the discussion method, with an understanding and as a separate program.* (Female teachers)

Shyness was also noted as an issue in class:

> *Adolescents are not open and not telling those directly. They don't even notify through friends, thinking it might get publicised. How much ever we say they don't even tell it to the teacher, because they think that it might get criticised in some other place.* (Teacher counsellor 2)

Participants not only noted possible solutions to overcoming embarrassment and shyness, such as discussion approaches to teaching and separate classes for males and females, but also age orientated education.

Others felt that ASRH education should start earlier in school: "So I would like to suggest, teaching on these must start from year 6 even in a very simple manner, like introducing adolescence." (Female teachers)

A need for proper evaluation of subjects involving ASRH was mentioned, along with a need for student assessment in this area: "Evaluating those subjects and incorporating questions to the term tests, covering those subject matters is important." (Principal 6) This relates to discussion focused on improving the quality of ASRH information provision at school as school provides a captive audience:

> *Because, school is the best place for them (health staff) to meet adolescents. They compulsorily come there. It is difficult to approach them one by one. So I think we have to take much more benefit out of that place.* (MOs)

Such improvements were only seen as possible if the support of senior education decision makers was present: "I think it is important if we can intervene up to some extent at the departmental level for providing." (MOs)

Special programs

The focus group discussion and key informant interviews contained many references to a number of school-based ASRH programs. These included Ministry of Health and Education initiatives as well as partnership endeavours with NGOs and UN agencies. A number of issues were raised by participants around the sustainability of these programs.

Ministry of Health ASRH health education materials were deemed useful, but a female teacher stated: "The distribution was stopped. As far as I know, no extra-curricular activity was implemented after that." A similar comment was made about a UNICEF program: "That was stopped in the midway, we got only the resources. We had an expectation of something more worthwhile. There are equipments which we have no idea on how to use." (Teacher counsellor 3) In addition, a Ministry of Education zonal level Psycho Social Intervention Program, although a useful initiative, was criticised for not properly consulting with all stakeholders and poorly selecting teacher counsellors, which impacted upon low retention rates. One Principal highlighted the need for all programs to be aligned with the school curriculum:

> *There is a need for activities to be introduced that are parallel to the curriculum. This could involve; maintaining a suggestion box to express the problems, ideas and suggestions of the students, conducting leadership and counselling workshops, conducting extracurricular and subject related projects according to the ideas of the student and introducing a student to personality development activities assessing scheme.* (Principal 5)

ASRH Counselling

Counselling services across the health, education, NGO, faith-based and local administrative sectors were discussed by providers. Providers reported a need to have "continuing counselling services in all the schools" including the appointment of a well-trained counsellor, "the necessary facilities "(Principal 2) and "a proper methodology" (Teacher counsellor 5).

Problems of teacher counsellor turnover were noted, and frequent staff changes often left positions unfilled or temporarily managed by others who were not necessarily trained:

> *Earlier there was a counselling service. But that gentleman got a transfer with a promotion to the educational office (regional). Then this teacher handled that for some time.* (Female teachers)

Teachers also address adolescent concerns by encouraging discussion and answering questions, and felt that in order to do this effectively they needed to develop a good relationship with adolescents.

Other issues raised were related to the perceived lack of confidentiality in school counselling sessions, impacting upon student demand for these services. According to an MO, this was due to the conflict in roles between teacher and counsellor, something they felt was inappropriate:

> *There is a problem in providing sexual counselling through the teacher. Because, there is a problem on privacy. How do students face the teacher after sharing his/her problem? Teacher may share this information with another party, which is also a possibility. I think it is better to give that responsibility to an outside person, because there is a risk as such. It has to be handed over to a doctor or to the medical service which is operating in Sri Lanka.* (MOs)

This was not regarded as a concern of one Principal:

> *A separate counselling service is not required. It is sufficient if every class teacher is having close relationship with students and provide personal and general advices after identifying the problems of them.* (Principal 3)

Although participants noted that counselling services were provided by other sectors, they highlighted the lack of access to these due to lack of knowledge: "Most of the time, youth don't know even where the counsellors are" (PHNS), and geographical distance:

> *If we take Beruwala as an example, there is only one in Aluthgama. So it is in this end and the other end is many kilometers away. There might be villagers in villages like Payagala, Hinatiyana, Koshena who have not come to Aluthgama for their entire life. These services must also reach the rural villages like Halkandavila.* (PHI)

Workforce issues in ASRH in Sri Lanka

Provider Roles

The roles and duties of providers affect the scope of their practice and the way in which collaboration within and between sectors may occur. Key themes that emerged centred on roles specific to health or education providers, provider characteristics and the issues or changes relevant to those roles.

Health providers perceived their roles to be diverse and varied, including providing awareness/knowledge; providing advice; health promotion; establishing bonds with the adolescents; and discussion or counselling. Notably, there was limited discussion among the health providers of clinical roles such as performing vaccinations, breast exams, pap smears, STI testing, etc.

Awareness programs and lectures are conducted at a variety of locations including clinics, schools, YFSCs, villages and religious settings. Providers teach about SRH, including STDs and teen pregnancy:

> *We conduct awareness programs with the public health inspectors in schools through the health societies in schools. We have also sometimes shown videos. We do the necessary things to provide the knowledge on sexuality for them.* (PHMs)

Providers felt that parents and other adults in contact with youth also needed to receive knowledge about adolescent health, and that their role includes educating this population about the problems faced by adolescents, and how to 'protect' them:

> *Like that, this awareness must provide to parents, groups of people who frequently meet youth such as tuition teachers, without confiding it only to the youth groups. Also groups like three-wheeler drivers, employees in the hotel sector. I think is it important for us to empower even them on what is youth, the difficulties face by youth due to problems and how we can protect them from those difficulties when it comes to sexual activities.* (PHIs)

Providing advice to adolescents about sexual health concerns, such as contraceptives and family planning, was considered a significant role by a number of providers, especially the Estate midwives and PHNSs. Providers also offer advice to parents with adolescent children facing reproductive health issues:

> *We mostly talk to parents who are having adolescents with sexual and reproductive health problems. For example, we talk to parents of a girl who is having teenage pregnancy. Because the ideas of the parents on these kind of problems is very important.* (Estate midwives)

Providers are involved in health promotion and inform adolescents about the services available to them, such as services at the clinic, and access to contraceptives.

Many providers thought that it was important to bond with adolescents so that adolescents felt comfortable accessing services and discussing problems. In the discussion, counselling was perceived to be an important role of many providers, either in youth group settings or at schools/clinics, especially given that "...their peers...sometimes provide erroneous answers for their problems..." (PHIs).

Health provider characteristics

Health providers identified a number of qualities or characteristics they thought were desirable in a health provider. These included being female (one MO felt that because she was a mother as well as a doctor, this made her more approachable to both adolescents and other parents); and having undergone special training for communicating with adolescents.

Role perceptions – education providers

Like health providers, teachers saw their roles as diverse, but focused firstly on providing SRH knowledge to adolescents in schools. Teachers also address adolescent concerns by encouraging discussion and answering questions, and felt that in order to do this effectively they needed to develop a good relationship with adolescents:

> *We have to develop close relationship among parents-children and teachers-students. Then if there is a problem the child will speak out. Sometimes couples run away from their homes, but even the closest friend knows nothing about it. Why? Because, people are not having close relationships.* (Male teacher)

Teachers also felt they were responsible for intervening and 'rescuing' adolescents with problems. For example, the male teachers described an incident where a boy in year 5 was exposed to porn films: "..after that he didn't come to school. He was spoiled. We couldn't rescue him."

Principal 2 described another responsibility of teachers as being involved in more holistic education for the adolescents, such as motivating students to "combine this (reproductive health) knowledge with the dignity and self-esteem of their practical life…" and to describe the repercussions of 'foolish' activities.

Perceptions of the teacher counsellor role varied somewhat between principals and counsellors themselves, but most agreed that the role of counsellor was critical to adolescent health: "The counselling teacher acts a major role." (Principal 2)

Principals described the role as meeting with adolescents and their parents to discuss problems, rehabilitating students who had been abused; and generally intervening with adolescents identified as having problems.

While some counsellors acknowledged their role to individually counsel students, they placed greater emphasis on awareness training provided to groups of students, discussing issues such as likes and dislikes; career options; how to face life challenges, and how to "win life" (Teacher counsellor 5).

> *I may be discussing about a poem or may be discussing on how to observe the nature, through that I slowly provide them, without their knowledge, the idea on how to face the challenges of life.* (Teacher counsellor 8).

Principals saw their roles to be administrative rather than relating directly to adolescents, including providing opportunities for ASRH awareness programs; providing relevant training for the managers and secretarial heads in the schools; consulting with and maintaining a good relationship with outside sources such as health officers and the Probation and Child Protection Office; and making students aware of laws which relate to them (Principal 5). Teachers and teacher counsellors did not comment on the role of the principal.

Education Provider Characteristics

Respondents identified certain desirable provider characteristics. For example, some male teachers felt that they were better equipped than female teachers to teach ASRH:

> *When we compare teaching of these (sexuality) by a female teacher and a male teacher, students listen more if it is a male teacher. The tendency to tease or make unnecessary jokes is less. A male teacher has that ability to control. Secondly lady teachers don't explain it much. She does this without going into details. Because, she might have to face such problems (teasing).* (Male teacher)

However, other male teachers felt that female teachers could be superior in their teaching and that the critical factor was the teacher's personality: "There are instances where lady teachers deliver more effectively than a male teacher. There are instances like that. That is something goes with one's personality." (Male teachers) Female teachers did not comment on gender distinctions.

Teacher counsellor 7 suggested that counsellors should be knowledgeable:

> *I think a counsellor should be a person who is having so much knowledge in so many fields. He should be a person from whom a child can acquire something. Actually he must be a person who is spiritually developed. A child can acquire a lot from a person of that sort...* (Teacher counsellor 7)

Current knowledge skills and attitudes

The quality of ASRH service delivery is critically dependent on providers in all sectors having accurate knowledge about ASRH and feeling confident in their skills for undertaking the duties attached to their roles. These attributes specific to health providers and education providers, as obtained from the KAP survey and focus group discussions, are discussed below.

Health providers

Results from the survey give some insight into the current knowledge and attitudes of health providers. Just over half (55%) of all health providers advised adolescent clients to use condoms as a protective and preventative measure of contracting STIs. Of the remaining providers, 42% were unable to remember what advice they offered clients, which demonstrates a poor attitude toward contraceptive use.

Similarly, when asked about how comfortable providers were in discussing sexual and reproductive health issues with adolescents, only 13% said that they were very comfortable. Just over a quarter of health providers (26%) said they were comfortable, however, the majority of respondents (40%) reported feeling somewhat uncomfortable. The remaining providers did not respond to the question. This discomfort may reflect poor knowledge/attitude towards ASRH, or perhaps doubt in their abilities.

FGD findings revealed that many providers felt motivated simply by knowing they were helping adolescents and, because of this, expressed a desire to improve their knowledge and skills towards ASRH. For example, PHNSs wanted opportunities to develop their current knowledge, skills and attitudes in regards to scientific developments.

MOs commented on societal attitudes, feeling that they needed to change before any other changes, such as funding/policy changes, could take effect:

> *The attitudes of all the social levels have to be changed, such as administration, top administration, teachers, parents etc...The attitudinal change has to be done while staying within the boundaries of the culture.* (MOs)

FGD findings revealed that many providers felt motivated simply by knowing they were helping adolescents and, because of this, expressed a desire to improve their knowledge and skills towards ASRH.

Education providers

The KAP survey of teachers asked what action they took when faced with an ASRH 'problem' – 21% responded 'don't know', and only 43% felt able to deal with the situation themselves by offering counselling to the student themselves; up to 50% would refer to counselling from another source (figure 3).

Principals and MOs were concerned that teachers lacked the necessary skills and knowledge to teach sexual education properly. MOs suggested that they should be responsible for teaching sexual education in place of teachers:

> *Teachers don't teach these properly even though it is included to the curriculum. So what they have to do is to transfer that responsibility to a doctor. One can easily find a doctor. It would be convenient because we even have a school medical service.* (MOs)

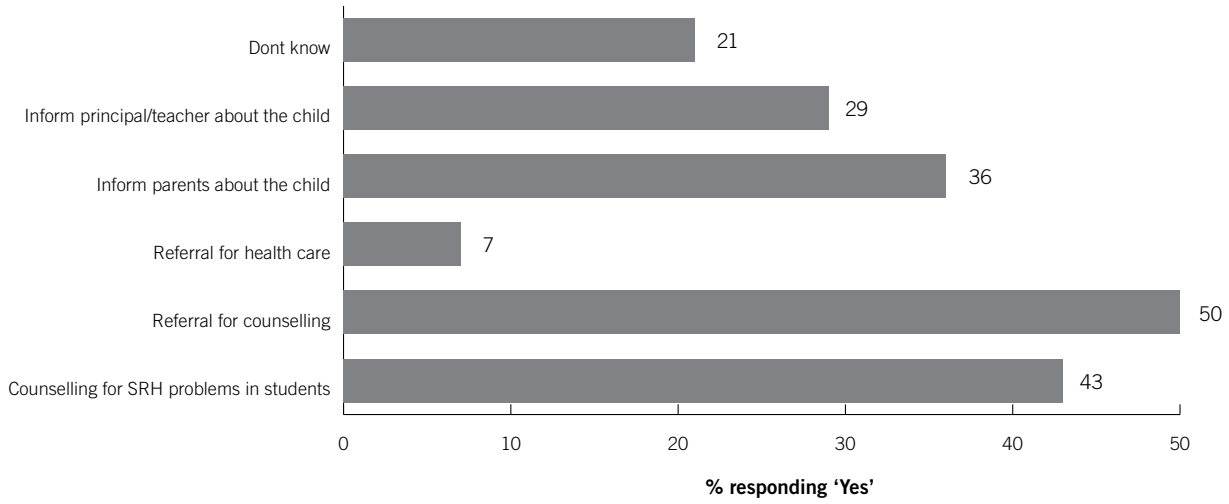
Teacher embarrassment (especially among female teachers) prevented some from teaching properly:

> *Sometimes even the teacher, if the teacher is young, boys joke even him/her. I have seen teachers in this school who had got in to that situation. They come and tell us, it is difficult for us to teach because boys start to laugh for these things. Then girls become shame-faced and hide their faces. So after that, the teacher writes something on the board and finishes the lesson hurriedly. So it gets in to that situation.* (Female teachers)

Teachers also reported having reservations about teaching SRH to adolescents; many believed that adolescents would misuse the information:

> *With this situation, if we provide education they can go a step further. We may be taking the risk of amplifying the destruction when compared with what is happening at present by providing education.* (Male teachers)

FIGURE 3. ACTION TAKEN BY TEACHERS WHEN FACED WITH AN ASRH PROBLEM



This reserved attitude of teachers and other education providers was also noted by the MOs:

> *People in the schools don't like to see us coming to do programs. They give the opportunity when we go to medical inspections only because it is compulsory, and they don't care. When we go to ask for a date for a program they become long-faced and say we have this thing and that thing, before giving it.* (MOs)

On the other hand, motivation to help adolescents through ASRH education was also evident among some providers:

> *I am doing this as a service (voluntarily) and I am happy about it. Nobody knows about these, but it makes me happy because I know how many students became happy due to this.* (Teacher counsellor 4)

Male teachers perceived that a benefit of providing SRH knowledge to adolescents was that it 'controlled' adolescent curiosity: "The curiosity at the age of adolescence is something occurs due to physiology of the body....We cannot avoid that. What we can do is controlling it up to some extent. Providing knowledge and controlling." (Male teachers)

Management of staff

Management is a source of leadership for providers in both sectors. Those working in managerial roles have the responsibility for developing job descriptions, organising resources, supporting providers in the performance of their roles through appropriate training and supervision and generally communicating the importance of ASRH to providers and other stakeholders. Perceptions of staff management by health and education providers are discussed below.

Health providers

When discussing management, health providers focused on needing a clarification of roles, as allegedly the job descriptions do not match their perceived roles. According to PHIs this can cause problems with follow-ups, as these are not included in job descriptions. "Other thing is that we don't have the opportunity to do a follow up even though we refer the youth to someone. We can't go after it because it is out of our duty." (PHIs)

PHIs said that although reproductive health was in the job description, it was not specified for youth: "There is a connection in an indirect way. But it is not described directly in the job description. But there is an indirect connection." (PHIs)

Providers also discussed problems with evaluation of services, mostly due to ASRH not being included in a summary of daily work; and due to a lack of clear indicators for assessing their performance. "There is also a problem regarding the datum for measuring, because when we provide counselling there will be a qualitative development but quantitatively it seems very small." (PHIs) This inadequate performance assessment

reportedly leads to a reduced motivation to perform tasks outside of provider duties, but these are required in order to meet performance expectations:

> *So, generally there is a possibility of focusing on our compulsory duties by giving up these extra duties. Negligence may happen due to going after our targets with the pressure of our superiors. If not, we might not be able to achieve our targets in the evaluation at the end of the month.* (PHMs)

Education providers

Education providers also felt there was a need for clarification of roles. Some teacher counsellors complained that regular teachers tried to take on counsellor roles without the necessary training, with detrimental effects:

> *Teachers also try to do counselling due to their ignorance. Actions of some teachers were like throwing stone for something fragile. Actually they don't know the inside of the students.* (Teacher counsellor 8)

Role overload is also a barrier to effective ASRH education. For example, female teachers would like more time to attend to individual students' problems, but it was not part of their job description and they were already overloaded:

> *Yes, there is a problem with the time. If a personal problem of a student arises, we will discuss on it. We will take them separately and discuss. But with the weight (size of the content) of the syllabus, we can't go out of track with the available time (time is not enough).* (Female teachers)

Sports teachers are teaching both health and physical education but do not have adequate time to perform both duties, so are often skipping the health component:

> *So both sports as well as health have to be done by the same teacher. There are only three teachers there in the entire school...So when it is being done with sports activities, they miss the health subject.* (Female teachers)

Most teacher counsellors reported that they received full support from the principal for their role: "I was given the full freedom to do counselling in my previous school. I got the maximum support from my principal." (Teacher counsellor 7)

One teacher counsellor reported that their principal would always appoint a new teacher to be a counsellor as soon as he received a letter about a training program, but other than this there was little discussion amongst respondents about positions not being filled.

Most (health) providers wanted more opportunities to expand upon/update their current level of training. **Results of surveys indicated that 55% of providers had not received reproductive health training in over 10 years.**

Education and Training

Sound, comprehensive education and training of providers equips them with the knowledge and skills necessary to deliver quality services. Institutional study as well as on- the job training programs are involved. The main themes and categories that emerged from the qualitative data in relation to education and training are discussed with reference to each sector below.

Health providers

Most providers felt that existing education in ASRH was unsatisfactory, resulting in inadequate knowledge and skills. While basic education may have included SRH, training specific to providing reproductive healthcare for adolescents was almost non-existent. PHNSs stated: "We haven't received specific training related to reproductive health for a day, for a week or for a month."

Some providers were an exception. MOs felt that while they may not have received special training in ASRH, it had been covered sufficiently in their basic training: "No, anyhow we receive that knowledge in medical education. So I think a specific training is not required for doctors." (MOs)

All providers were dissatisfied with the lack of training for providing counselling to adolescents, and this was identified as a great need, given that providers viewed counselling as one of the most important needs of adolescents.

> *Now, when we think about the problems of the children, counselling is the most important. It is better if we are being provided with some kind of training to develop the special skills on counselling.* (PHIs)

Most providers wanted more opportunities to expand upon/ update their current level of training. Results of surveys indicated that 55% of providers had not received reproductive

health training in over 10 years. Similarly only 3% of respondents had had training in the past six months. Training gained on average in the past two, four and 7.5 years was 16%, 8% and 18% respectively. In particular, respondents said they were interested in gaining skills in technology in order to further understand the forms of communication used by adolescents:

> *... I think we need to acquire more knowledge which complies with the present day requirements. It is better if the knowledge on technology can also be provided along with this. (*PHMs)

PHMs were concerned that they did not have access to current, up-to-date resources such as books with which to update their skills or knowledge independently.

Education providers

Existing education for education providers seldom includes adequate specialised training for ASRH. Providers agreed special training for ASRH would be beneficial: "I believe no-one in here has participated for a methodical program on that (ASRH)." (Male teachers)

A teacher counselor also commented on the lack of training:

> *Other thing is that it is better if a proper training is provided. I think we may be able to do more than this for the children if we can learn and utilise the proper methods on getting closer to them and acquiring their information. Even though I have learnt this as a subject, I haven't gone through a proper training.* (Teacher counsellor 3)

Female teachers commented that sports teachers in schools were not sufficiently qualified to teach ASRH:

> *There are very few (sports) teachers who have done the Diploma in teaching science...Most of them have selected from lower qualifications and provided training. They are given knowledge once in a while through training sessions. Actually that is insufficient. We can clearly see the problem, that they are not competent.* (Female teachers)

Some providers had attended training programs but many had not, or were unable to remember the content of the training:

> *There were a few programs in Benthara (a town) covering two sections, which are drugs and sexuality. Actually, I can't exactly remember about the content of the program. But I participated for it.* (Female teachers)

The results of a survey which asked teachers when they had last received ASRH training showed that over 55% didn't know if they had received training; over 20% had no basic ASRH training; and less than 15% had received ASRH training in the last three to five years.

However, some of the teacher counsellors reported that the training they received had been beneficial: "I got the opportunity to learn methodically on this after 2006 with trainings. I think then I came to a level where I can provide counselling in an appropriate manner." (Teacher counsellor 8).

Many providers felt that more comprehensive training was required for counselling skills; one teacher counsellor commented: "..at least 75% of the schools need well-trained counsellors. It has not happened yet." (Teacher counsellor 8)

Counsellors commented on the need for training to update current knowledge/skills:

> *So I think the person who is doing this must get trained frequently. If we cannot be given frequent training, we should have given training for particular time period. We should be refreshed on this again, after that duration.* (Teacher counsellor 7)

The enabling working environment

Building and maintaining a supportive working environment that promotes mutual respect and personal dignity and provides access to essential equipment and infrastructure is essential to worker motivation, performance and productivity. An overview of the key themes that emerged from the KIIs and FGDs is detailed below.

Health providers

Health providers reported that support to deliver ASRH services was somewhat limited. Financial assistance and support in training programs from UNFP was discussed. However, MOs felt that funds from external sources were inconsistent and unreliable. Support from other providers was briefly mentioned; for example, PHNSs appreciated the assistance they received from MOs in their training programs.

Barriers identified to provision of quality ASRH services were primarily lack of funds; lack of facilities/transport; large population of duty; and cultural barriers.

All types of providers felt that appropriate transport was an issue. PHMs often had to walk a considerable distance to visit their patients or use personal resources to arrive there. Even where motorbikes were provided, fuel was not: "We have to

pay for the petrol from our pocket." (PHMs) Other providers agreed that lack of transportation was an issue, and that use of personal resources was the result: "Most of the time we are using our personal resources for these (transport), actually these things (duties) proceed due to our commitment." (PHIs)

Other resources and facilities deemed inadequate included teaching materials such as multimedia materials for education purposes, and an appropriate confidential area to use for discussion/counselling. MOs expressed a need for improved facilities and resources:

> *We don't have transport, we are not provided with required equipments, we are not provided with necessary knowledge, we take care of everything and we are even providing it also. We don't even have a multimedia to do a presentation at a school. What I want to say is give these things to us. We are doing these up to what we can even without having them.* (MOs)

Providers were also concerned with unrealistic duties in large target populations: "...we do all this while having a huge work load in our duties...we can't deploy enough time for these issues with our work load." (PHIs)

Providers also identified cultural barriers, mostly in relation to providing ASRH services to the Muslim community. They thought that language differences (i.e. providers unable to speak Tamil), as well as cultural taboos, made it difficult to speak openly with this population.

Evidently, solutions and suggestions given by providers generally aimed to remedy the issues they had described. The need for better funding was strongly emphasised, and PHIs suggested that acquiring necessary transport and other facilities would be helpful:

> *...if we are provided with equipments which are required, motor bicycles, petrol for them, leaflets and the resources which mentioned earlier.... then I think we would be able to continue these [programs] without any obstacle.* (PHIs)

Providers also requested resources to allow them to acquire skills in using technology:

> *Now, it is mentioned that we also have to join hands with the new technology. I think we can effectively convey by showing something (using multimedia) and making them to see that the result will be like this, rather than giving speeches to them. I think it is better to utilise the new technology, than giving speeches.* (PHMs)

Teacher counsellors were concerned by the **unavailability of classrooms with a suitable (private) environment for counselling.**

PHIs requested an opportunity to learn Tamil, which they felt would remedy the language barriers discussed earlier.

Providers also agreed that there was a need for a policy to clarify their roles and duties, and that in many cases the population of duty needed to be reduced.

Education providers

Discussion of supportive factors in the work environment was limited to support from peers, such as counsellors discussing appropriate solutions for students; and in a few cases, proper facilities such as private rooms for counselling. However, discussion among providers focused mainly on issues/needs. The main issues covered were lack of facilities/resources; large workload; and cultural barriers. Teacher counsellors were concerned by the unavailability of classrooms with a suitable (private) environment for counselling: "That is one of the biggest obstacles which I am facing. There is no such a place." (Teacher counsellor 1)

All providers reported the large workload they were assigned to, combined with time constraints, as being a barrier to providing quality education.

Teachers were sometimes hesitant to discuss issues openly with adolescents because of perceived cultural taboos: "Difficulties mean, when we are teaching something like this, students coming from different cultures, family backgrounds, social levels etc. are there in the same classroom." (Male teachers)

Teacher counsellors requested a separate classroom with a sign illustrating a 'counselling service':

> *But we can do this more efficiently, making proper decisions, maintain reports etc. if we have something like that. Then the students also will have a place to go when they are having a problem.* (Teacher counsellor 4)

Teacher counsellors also felt it would be beneficial to have more opportunities to share experiences: "Also, there should be opportunities to share experiences among counsellors...I think it is like among doctors, sharing experiences among

each other will speed up achieving of results." (Teacher counsellor 7)

Collaboration: opportunities and issues

Collaboration emerged from the interviews and focus group discussion as an important part of service provision. Discussion by providers centred on explanations around the need for collaboration and suggestions for approaches to collaboration.

Need for Collaboration

Providers felt that improved communications between the health/education sectors, and improved inter-sectoral collaboration would be beneficial to ASRH service delivery. MOs advised that economic and political commitment was required, and that the Health and Education ministries should form shared policies to achieve this:

> *I think there has to be a policy decision on sexual education... Educational ministry and Health ministry have to get together and must take a good policy decision. These two sectors have to get together to do this in a better way.* (MOs)

Providers felt that formalised relationships between cadres and professions were needed to clarify team and individual roles and responsibilities:

> *All the health officers must understand their responsibility as individuals and as groups. We need to have better coordination than at present among the health sector personalities... and other government servants who are attached to this field.* (PHIs)

Along with this, PHNSs commented that strong relationships and teamwork between cadres could result in successful programs, as responsibilities and blame would then be shared among many:

> *A program will be successful if a teacher, health officer, a doctor, may be a leader of a society is present. Then parents cannot blame anyone.* (PHNS)

Examples given of collaboration already occurring between sectors included:

- Support from the local government, such as Estate midwives receiving assistance with programs from the Grama Niladhari;
- Youth service officers and youth societies inviting health workers to youth clubs;
- Community members, such as peer educators, or mothers associations, volunteer to help with health awareness programs;
- NGOs such as Red Cross, TRUST and UNFP provide funds for sexual education programs and distribute condoms etc.;
- Faith-based organisations such as the Salvation Army conducting programs at their churches;
- Collaboration with the justice sector, through established services at the community unit in the police station;
- Support from some businesses.

Suggestions for approaches to collaboration

Providers suggested that a single service centre point at community level was needed, with education and clinical services acting as a point of delivery for all referrals and a place where providers could build relationships with youth:

> *I think it is better to establish centres to provide knowledge… Because someone goes only to a place has built the trust… I think it is good, if there is a centre which has been provided with necessary knowledge for persons who are in the same age, there should be one even at least for two villages.* (PHM)

In addition, providers indicated that a proper evaluation of collaboration efforts at a government level would further encourage communication between the different sectors. One PHI said: "There has to be an evaluation in the government service for this. With that appreciation, it will be able break the obstacles and go forward."

Some providers, especially male teachers, raised issues with NGO involvement as they reportedly 'force' sexual education and do not teach within appropriate cultural boundaries:

> *My personal opinion is that NGOs should not get involved in here. They openly share the story (facts on sexuality) among them… NGOs from different areas, different state institutions, have made sexual education a giant.* (Male teacher)

However, notably many providers reported that assistance from NGOs was of value to their services.

DISCUSSION

This study explores the barriers and enablers to health and education personnel delivering ASRH to adolescents in Katutara district. It describes how health and education personnel deliver information and services to adolescents, and identifies the factors that guide and influence professional practice, as well as the collaboration that occurs between these sectors and others in delivering ASRH.

As the study is a pilot, it is not known if the findings are representative of health and education providers across Sri Lanka, however some findings, as noted below, concur with those from other studies confirming the need for inter sectoral collaboration. Parents and adolescents were not involved in this study as the focus was on providers, however their participation would have elicited information regarding the perception of provider interaction and satisfaction with the services and information. Despite this, the professionals interviewed in this study have provided a greater understanding of how collaboration could be facilitated and sustained through cross cadre training and performance management and better supported through evidence-informed policies and program evaluation.

ASRH services and programs: issues and challenges

In the focus group discussions and key informant interviews, health and education providers identified a number of adolescent needs for SRH knowledge, access to commodities and counselling. However, the current services were not regarded as adequate to serve these perceived needs. For example, there is a reported lack of school counsellors and comprehensive focus across the life skills curriculum. There is also a disconnection between information and contraceptive availability. Providers note that adolescents have little knowledge of contraception which is not taught in the school curriculum, however, condoms and emergency contraceptives are available for them to purchase in pharmacies.

Participants noted that low adolescent use of health and counselling services was linked to perceived lack of confidentiality, as well as the low confidence and motivation of providers. ASRH services were seen as a low priority and, despite several programmatic efforts, these were usually short term, poorly supported and sector specific. This resulted in poor adolescent awareness, as well as low demand and participation. Respondents noted a paucity of ASRH program evaluation which affected the ability of providers to improve and justify the continuation of programs.

ASRH services were seen as a low priority and, despite several programmatic efforts, these were usually short term, poorly supported and sector specific.

Providers reported that parental support for providing knowledge and access to ASRH information is often absent and, coupled with an unstable home environment, can contribute to the lack of openness about such matters. Some providers felt that this needed to be changed through greater parental involvement, as well as a focus on broader health programs developed within schools. This involvement may not only raise adolescent awareness and better tailor services to specific needs, but also stimulate demand for these services. These efforts could be strengthened through the involvement of other sectors, such as the garment factory industry, in health promotion programs. This would serve to capture not only teenagers who have left school, but also those working in jobs after school.

The research provides a number of examples of ASRH education, counselling and clinical services that are provided by MoH and MoE. They do not, however, appear to be in regular communication and there is a lack of a coordinated approach to the provision of services. Similarly, programs involving schools are not always aligned with the curriculum. In addition, the Estate sector was described as being separate to public service planning, resulting in a variety of services that are separately funded and may not reflect the needs and priorities of the population. Policy was regarded by the participants as a critical component in enhancing their ability to deliver quality service and information, as well as supporting and guiding a multi-professional approach across the sectors. They referred to policy not only at national level, but also at the facility level, to guide practice. It is therefore important to involve health and education providers in the development of policy in ASRH. Providers need to be consulted at key stages to ensure policy is not only appropriate and relevant but well supported to facilitate effective implementation.

Workforce Issues

Unsupportive attitudes towards the provision of ASRH services were evident among some providers. For example

some teachers felt that adolescents misused the knowledge they imparted and, as a result, teachers were more reticent to disseminate ASRH information. This study found, as others have (de Silva 2009), that many teachers did not believe that providing SRH knowledge to adolescents was appropriate – rather it served to encourage students to engage in inappropriate behaviour.

Provider attitudes towards teaching ASRH may also be related to their reported lack of confidence and preparedness to deliver SRH information to adolescents. Improving the teacher and teacher counsellor pre and in-service training curriculum in ASRH may help to enhance provider confidence and attitudes towards ASRH.

Some providers questioned the qualifications and abilities of other providers (e.g. male teachers had a low regard for female teachers' effectiveness and health workers questioned teacher ability). Joint teacher and health worker training could be a useful way of ensuring that these providers are not only clear about their roles and scope of practice, but foster relationships for referral and offer one another professional support. Gender awareness training may also help male teachers appreciate and place more confidence in the abilities of their female colleagues.

Many providers reported problems with job descriptions not matching duties; some providers felt frustrated that they could not provide some services they perceived to be important as these were not included in their duty statement. A lack of clear indicators for performance assessment perpetuates this issue, as providers perceived that if they performed services outside of their duties these were not recognised by management. This perceived inadequate performance assessment contributes to reduced motivation to perform tasks, such as follow-ups, outside of provider duties.

Providers also reported a lack of clarity in job descriptions leading to role confusion. Some teacher counsellors complained that regular teachers tried to take on the role of counsellor without the necessary specialised training, creating confusion among adolescents about where to access school counselling services. Dual teacher and counselling roles were seen as problematic. Participants noted that this not only affected the time teachers were able to dedicate to their counselling role, but that students perceived this to impact upon teacher confidentiality and hence were more reluctant to confide in them. Clear job descriptions and duty of care may help to build identifiable services with a budget line that would attract student demand and garner staff support.

Gender awareness training may also help male teachers appreciate and place more confidence in the abilities of their female colleagues.

Comprehensive, written job descriptions are needed to be presented to providers upon their employment and formally acknowledged by management. Distinction between regular teachers and teacher counsellors should be formalised in a recruitment policy, with differences in duties provided in job statements by principals and made known to students.

Reserved attitudes towards, and a number of knowledge and skills gaps around ASRH were noted, indicating a need for increased attention in terms of education and training. Low levels of contraception promotion and the discomfort health providers and teachers reported having towards discussing issues with adolescents could be addressed through supportive in-service training. Building the monitoring and evaluation skills of health and education providers would also assist in clarifying not only their own roles but those of partners and community members. In addition this could contribute to sustaining and improving successful ASRH program efforts. Workers with effective monitoring and evaluation skills would increase the capacity of organisations to justify the need for resources and improve the financial accountability of ASRH programs.

A recurring theme among providers was a reported lack of funding, resulting in inadequate facilities/resources. Greater prioritisation of ASRH through funding allocations and policy directives would precipitate a need for clear provider roles, scopes of practice, guidelines for collaboration and clarification of health and education sector responsibilities.

Providers recognised that communication across sectors needed improvement, and that improved collaboration would solve many issues and be beneficial to ASRH outcomes. They provided examples of collaboration already occurring between sectors, much of which was seen as positive. Evaluation of successful local collaboration efforts could be useful in finding ways to improve and implement further collaboration amongst these sectors. Collaboration between the health/education sectors is regarded as positive by many providers but has resulted in some role confusion. For example, MOs

were invited to teach at schools by school health societies but some felt that teachers did not welcome them. Clear job descriptions for the role of the health sector within schools would avoid confusion and conflict over duties. Policy formed by the Health and Education ministries may be needed to achieve this, and a proper evaluation of existing collaboration may assist in monitoring efforts. For example, the school health duties of PHIs could be expanded with the involvement of PHMs and school teachers and counsellors in a comprehensive school health program that involves parents and government and non-government sector organisations.

Some providers appreciated the importance of the assistance of NGOs in program delivery but many reported that the NGO workforce was insensitive to Sri Lankan culture, resulting in mixed feelings towards NGOs. Training/briefing of the NGO workforce on cultural norms and taboos in Sri Lanka could help to produce a more welcoming attitude of the community, and greater cooperation.

A number of providers felt that society still had a negative attitude towards ASRH education/health promotion, and that attitude change should be encouraged whilst remaining within cultural boundaries. Collaboration among sectors could be used to help achieve this, e.g. engagement with the faith-based sector could help the messages of health providers be accepted in a trusted context. Further involvement of parents, which providers requested, would also help to garner community approval for ASRH services. Providers reported that parental support for providing knowledge and access to ASRH information is often absent and, coupled with an unstable home environment, can contribute to the lack of openness.

This study also revealed strong health and education provider opinion regarding the role of the media in ASRH. This included views about where adolescents sourced information, the state of the current media, its effect on adolescent behaviour and the ways in which it could and should be harnessed for health promotion. This raised education and training implications around media literacy which could be ameliorated through improved health communication training for health and education providers to model appropriate behaviour and provide accurate information in culturally appropriate ways.

In terms of the mass media, responsible policy could be developed to guide media practice in the area of ASRH. Health and education providers could have a role in the development of media programming in various electronic, print and broadcasting formats through collaboration in the design, planning and evaluation of such programs. In addition, if well designed, these could be employed as health promotion tools in health and education teaching and learning contexts.

ASRH services may benefit from a comprehensive approach to health programming. Formalised education and health worker involvement in the planning, implementation and evaluation of these programs, along with adolescents and their families, may improve participation in youth programs and generate service demand through increased awareness and more responsive services. The involvement of these different groups may also help to foster a more positive attitude within society towards ASRH.

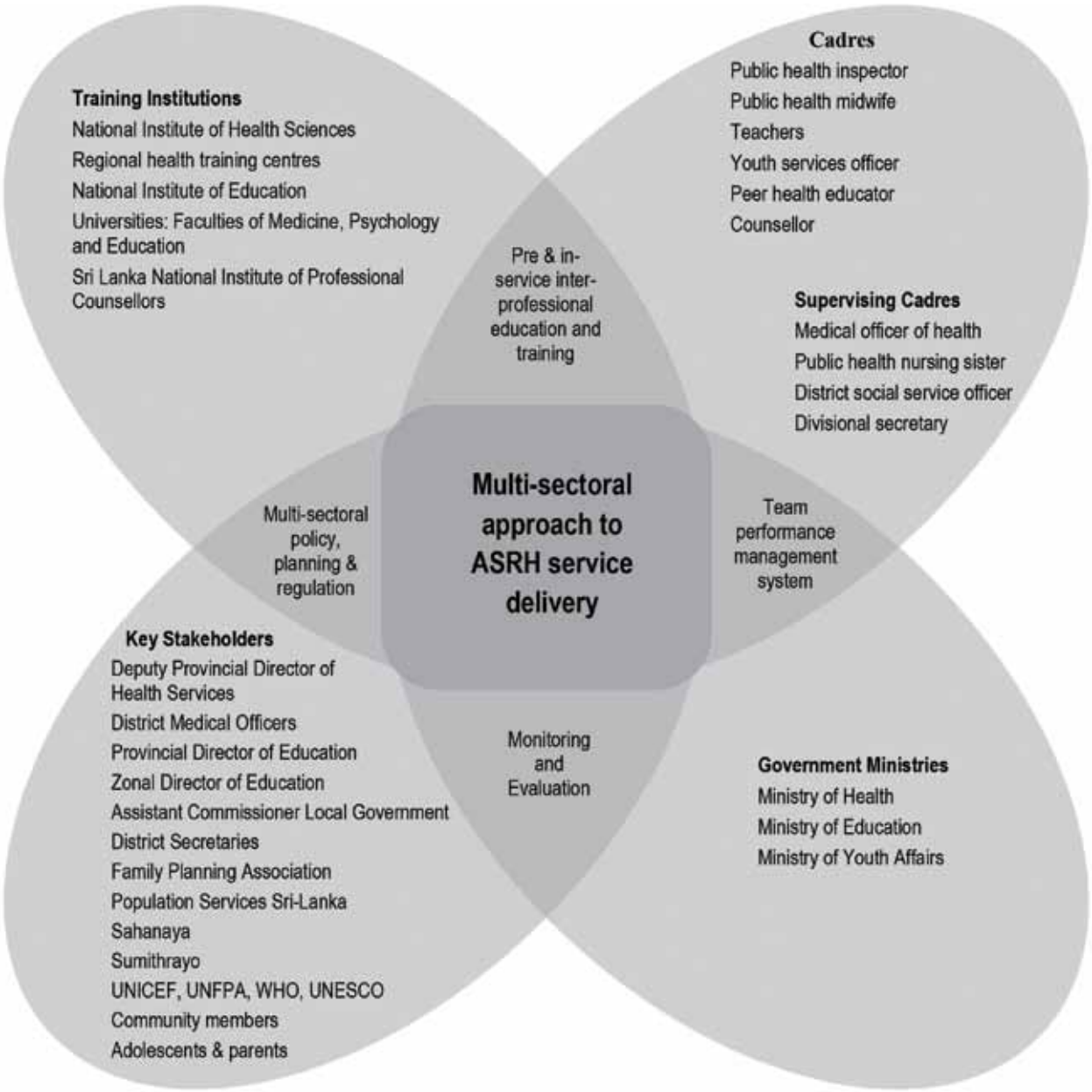
Ways forward

An approach that brings together inter-sectoral policy, planning and regulation as well as the pre and in-service education training and performance management of primary health workers and teachers can help to conceptualise the ASRH team, involve key stakeholders and garner the support required to deliver comprehensive care and services for adolescents in Sri Lanka. Figure 4 outlines the cadres, training institutions and key decision makers that could be involved in these processes. The approach needs to be underpinned by critical decisions concerning the minimum ASRH service delivery package (MoHN/WHO 2008), the roles and functions of all professionals and the core competencies needed to carry out such tasks.

We propose in our framework that pre-service education and training of all cadres would require appropriate and linked curriculum across all training institutions. Students could undertake several field placements and team ASRH assessment involving health education, clinical consultation, counselling and advocacy. This entails collaborative supervision from public health nursing sisters, medical officers, school principals, senior social service officers and clinical psychologists. In-service training should be regularly conducted that requires similar teamwork and supervision which is a necessary part of professional registration and linked to ongoing performance appraisal, promotion and career development in the workplace. This necessitates agreement across professional bodies, government ministries and provincial directors of health, education and local government. In addition NGO and UN programs should be coordinated with government efforts.

FIGURE 4. A FRAMEWORK FOR IMPROVING HEALTH EDUCATION AND TEACHER COLLABORATION IN ASRH

This framework acknowledges the wider context of ASRH. To be effective ASRH teams need to be motivated and properly prepared but also linked to community partners, adolescents and their families. This is an approach central to other frameworks for the provision of quality care such as Innovative Care for Chronic Conditions Framework (WHO 2002).



RECOMMENDATIONS

Based on the findings of our study, we propose a framework for improved cross cadre collaboration and skill sharing between health and education sectors in the provision of ASRH services and information. Recommendations are made in four key areas as outlined below:

Pre-service inter-professional education and training

- Development of an in-service joint education and health provider training program with focus on ASRH knowledge acquisition, skills building and attitude evaluation
- Specialised training for teacher counsellors
- Cultural competency training for NGOs
- Program planning and evaluation training should be incorporated into the pre and in-service training of health and education workers with ASRH included as a context example
- Media and social marketing training for health and education providers

Team performance management system

- Development of comprehensive job descriptions verified in writing and acknowledged by management.
- Formalised recruitment policy for dedicated teacher counsellor roles
- Development of performance assessment indicators which reflect ASRH health targets

Monitoring and evaluation

- Quality improvement processes to ensure ASRH programs are accessible, appropriate and acceptable – informing workforce roles and management
- Involvement of other sectors in this process including parents, NGOs and community organisations which will feed into planning programs and services

Inter-sectoral policy, planning and financing

Joint Health and Education ministries policy to:

- Clarify roles and responsibilities of health workers, teachers and teacher counsellors
- Facilitate better linkage between services, information provided through the school curriculum and commodity availability
- Ensure appropriate resourcing and long term vision
- Gain buy-in from multiple stakeholders
- Partner with the media and the Ministry of Communication to develop guidelines for responsible reporting and media coverage of ASRH including editorial and programming policy within media agencies, training journalists and resources to assist script writers to insert ASRH issues into story lines

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APPENDICES

Appendix 1 Map of Kalutara MOHs

Appendix 2 Organisation of Health at National Level

Appendix 3 Organisation of Health Services Under the Provincial Council

Appendix 4 Organisation of Health Services Under the Regional Director

Appendix 5 Duties of a Medical Officer

Appendix 6 Medical Schools in Sri Lanka

Appendix 7 Duties of a Public Health Midwife

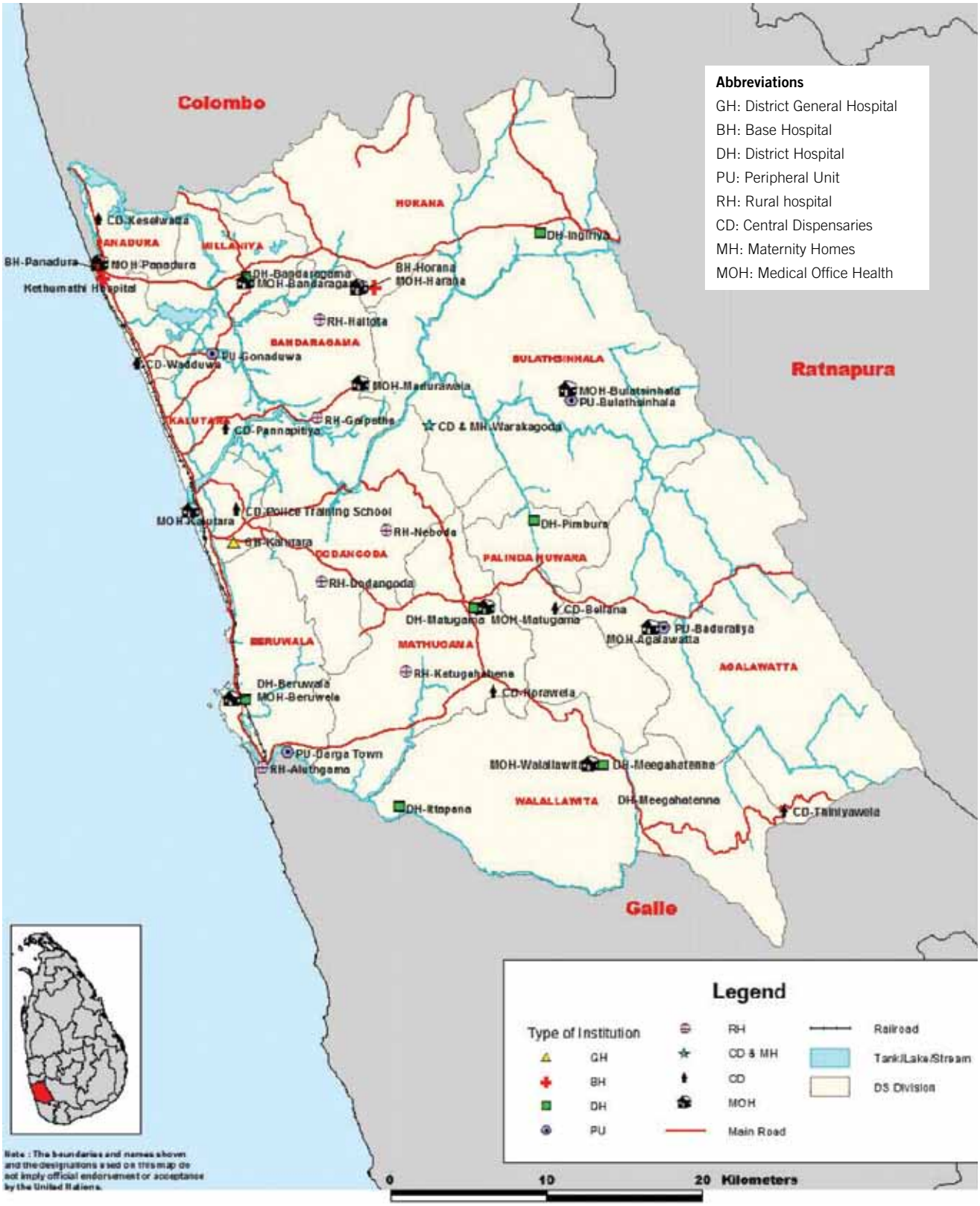
Appendix 8 Duties of a Public Health Nursing Sister

Appendix 9 Duties of a Public Health Inspector

Appendix 10 ASRH Content and Competencies in the School Curriculum Grades 6-13

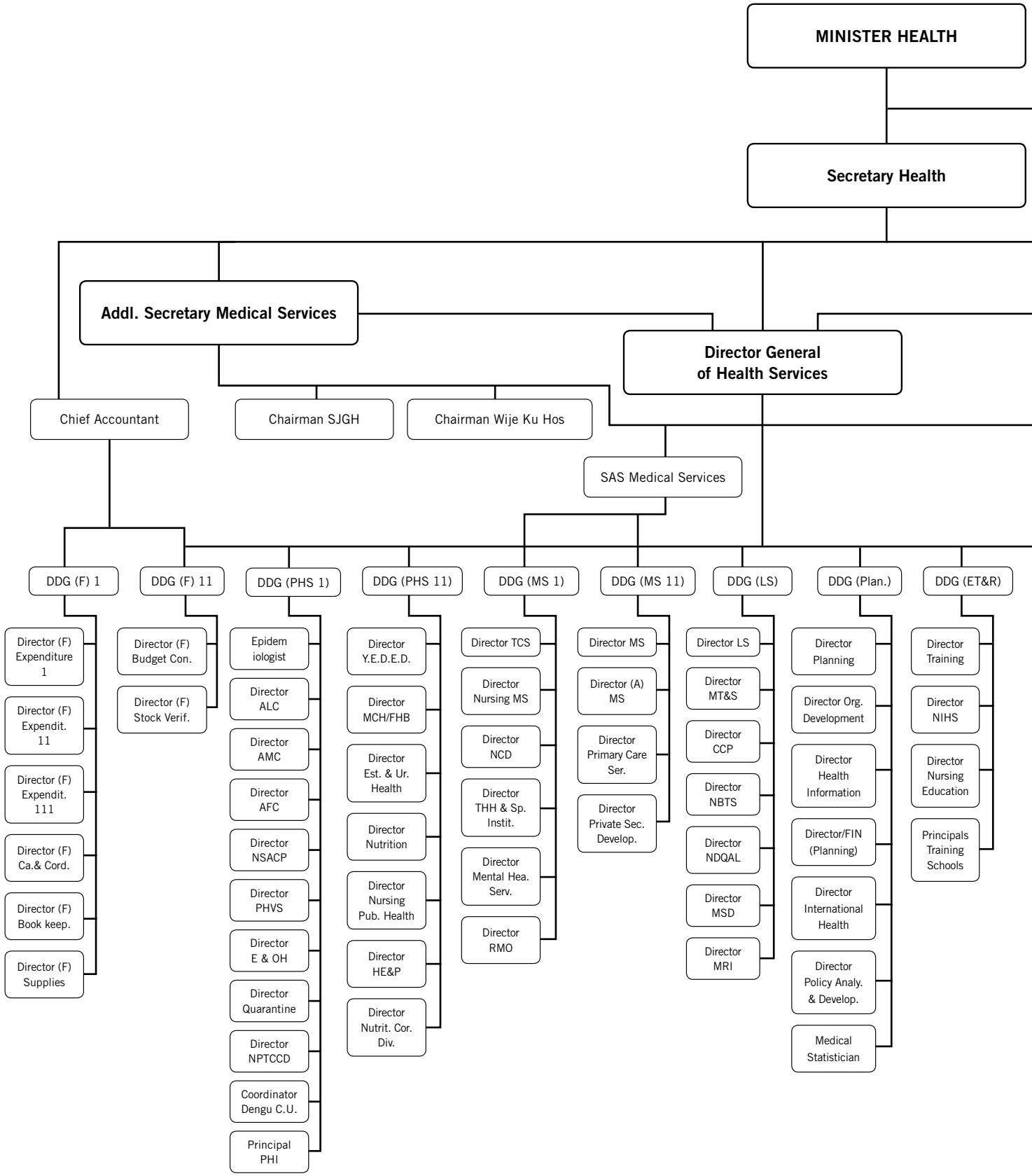
Appendix 11 Health Indicators for Kalutara District

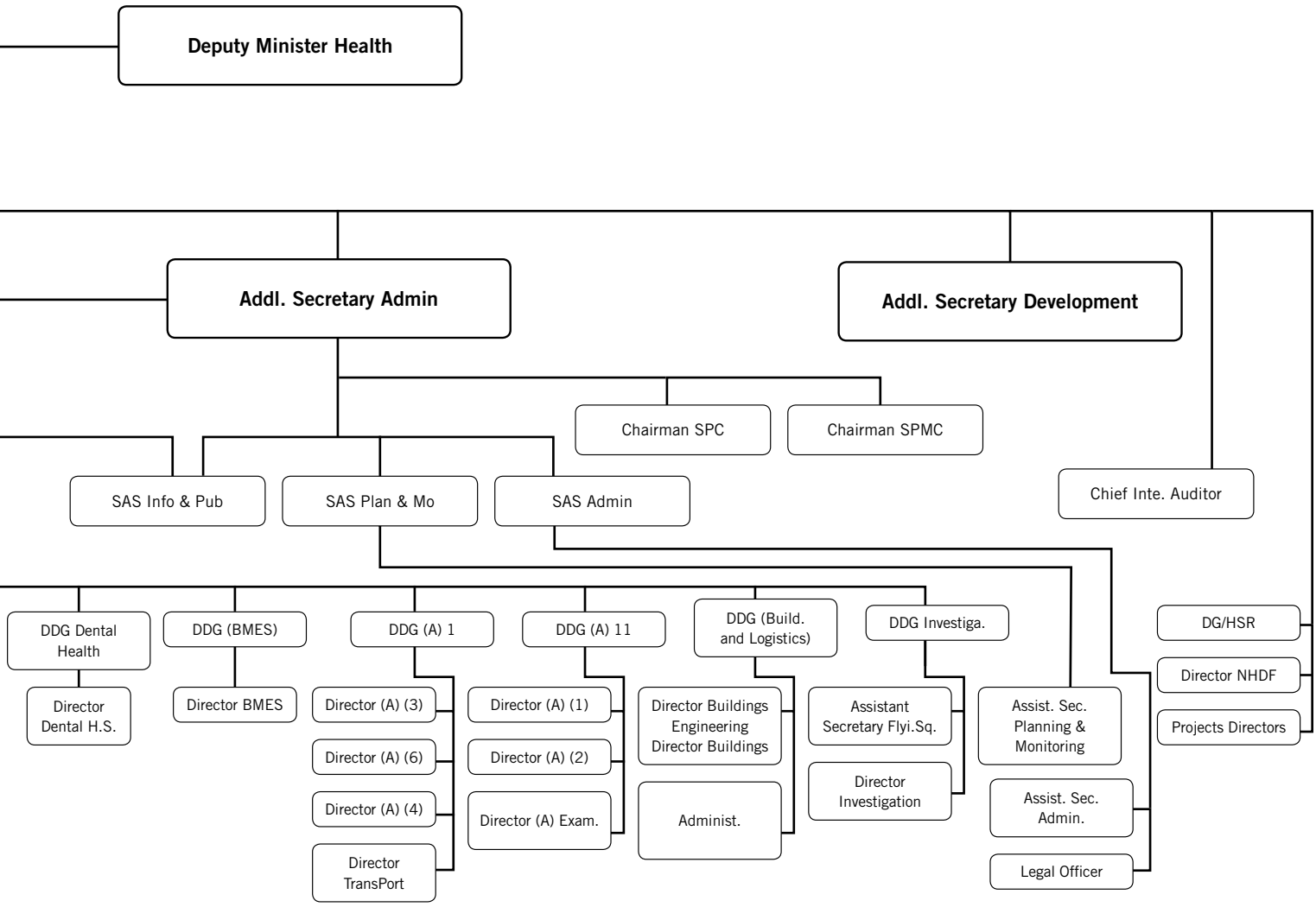
APPENDIX 1: MOH AREAS IN DISTRICT OF KALUTARA



APPENDIX 2: ORGANISATION CHART – MINISTRY OF HEALTH

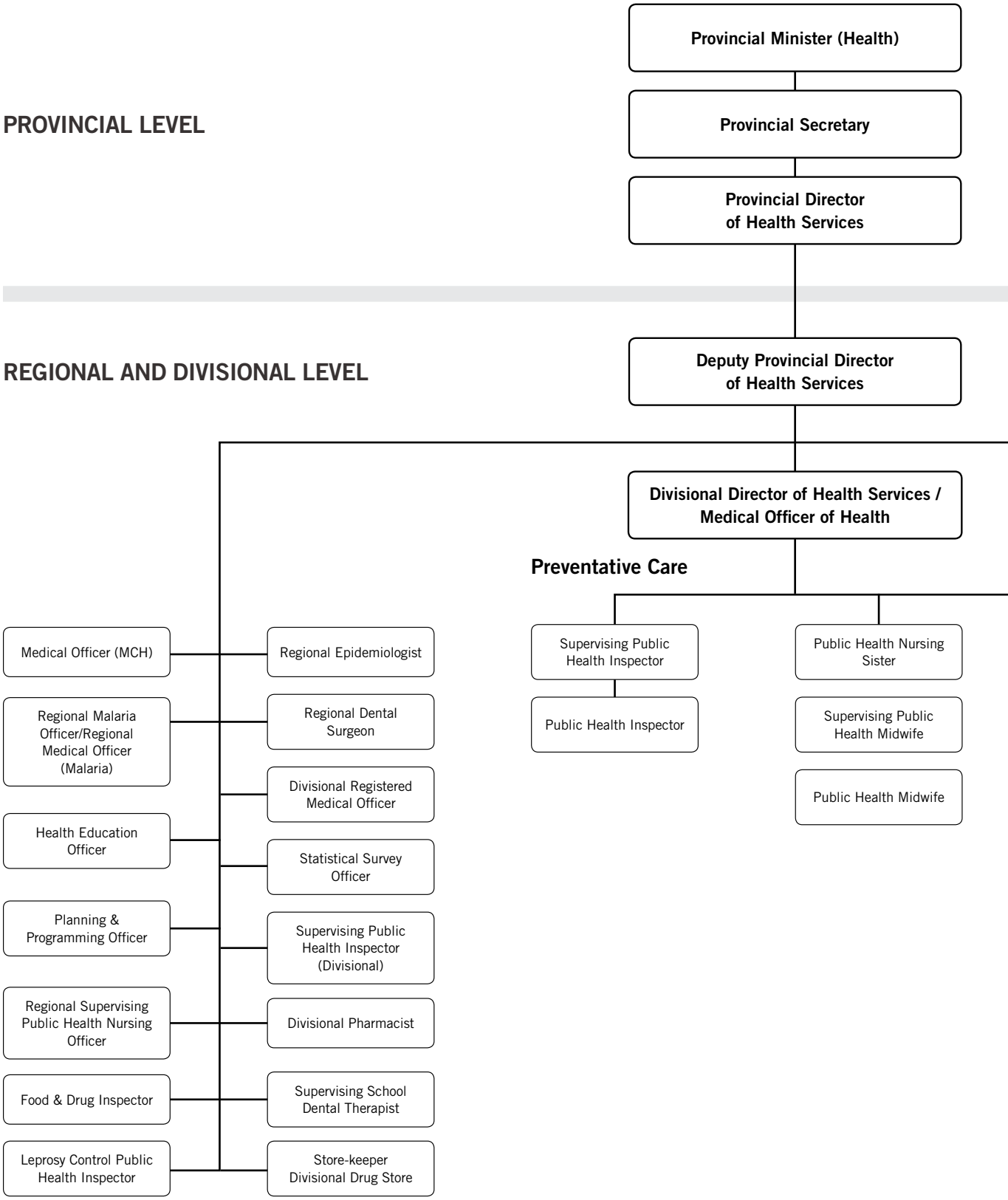
Updated May 2010
Source: Information Unit - MDPU www.health.gov.lk/OC-2010.pdf

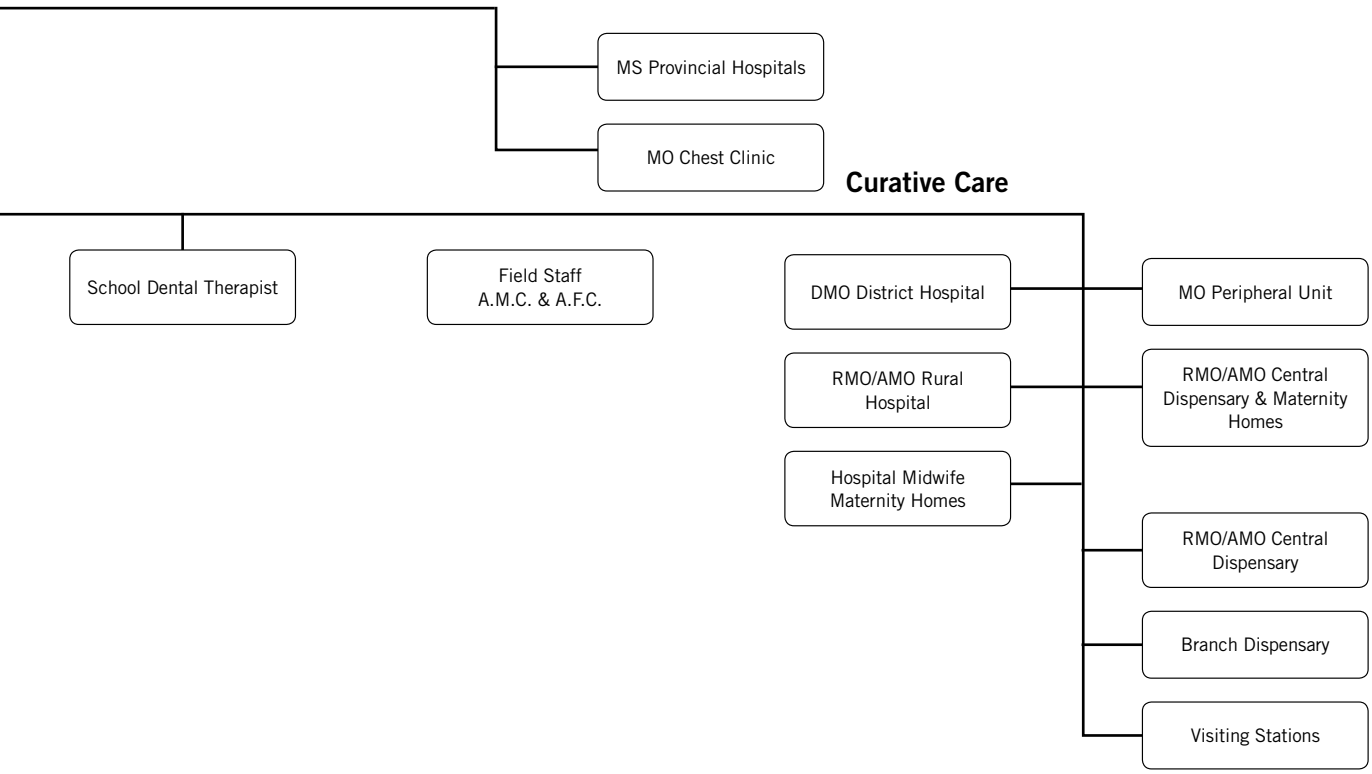



Deputy Minister Health
Addl. Secretary Admin
Addl. Secretary Development
Chairman SPC
Chairman SPMC
SAS Info & Pub
SAS Plan & Mo
SAS Admin
Chief Inte. Auditor
DDG Dental Health
DDG (BMES)
DDG (A) 1
DDG (A) 11
DDG (Build. and Logistics)
DDG Investiga.
DG/HSR
Director NHDF
Projects Directors
Director Dental H.S.
Director BMES
Director (A) (3)
Director (A) (6)
Director (A) (4)
Director TransPort
Director (A) (1)
Director (A) (2)
Director (A) Exam.
Director Buildings Engineering Director Buildings
Administ.
Assistant Secretary Flyi.Sq.
Director Investigation
Assist. Sec. Planning & Monitoring
Assist. Sec. Admin.
Legal Officer

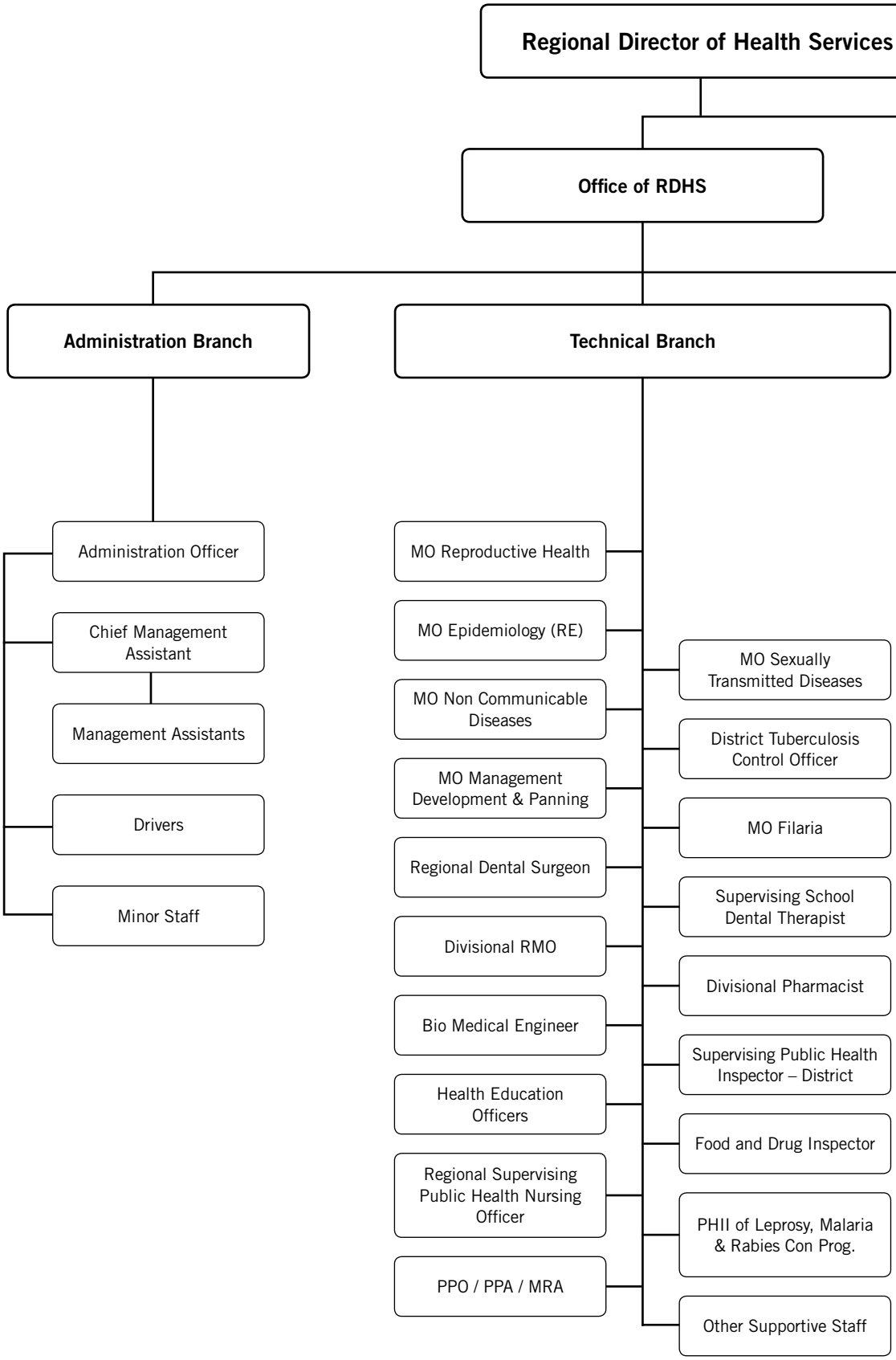
APPENDIX 3: ORGANISATION CHART FOR THE HEALTH SERVICE UNDER PROVINCIAL COUNCILS

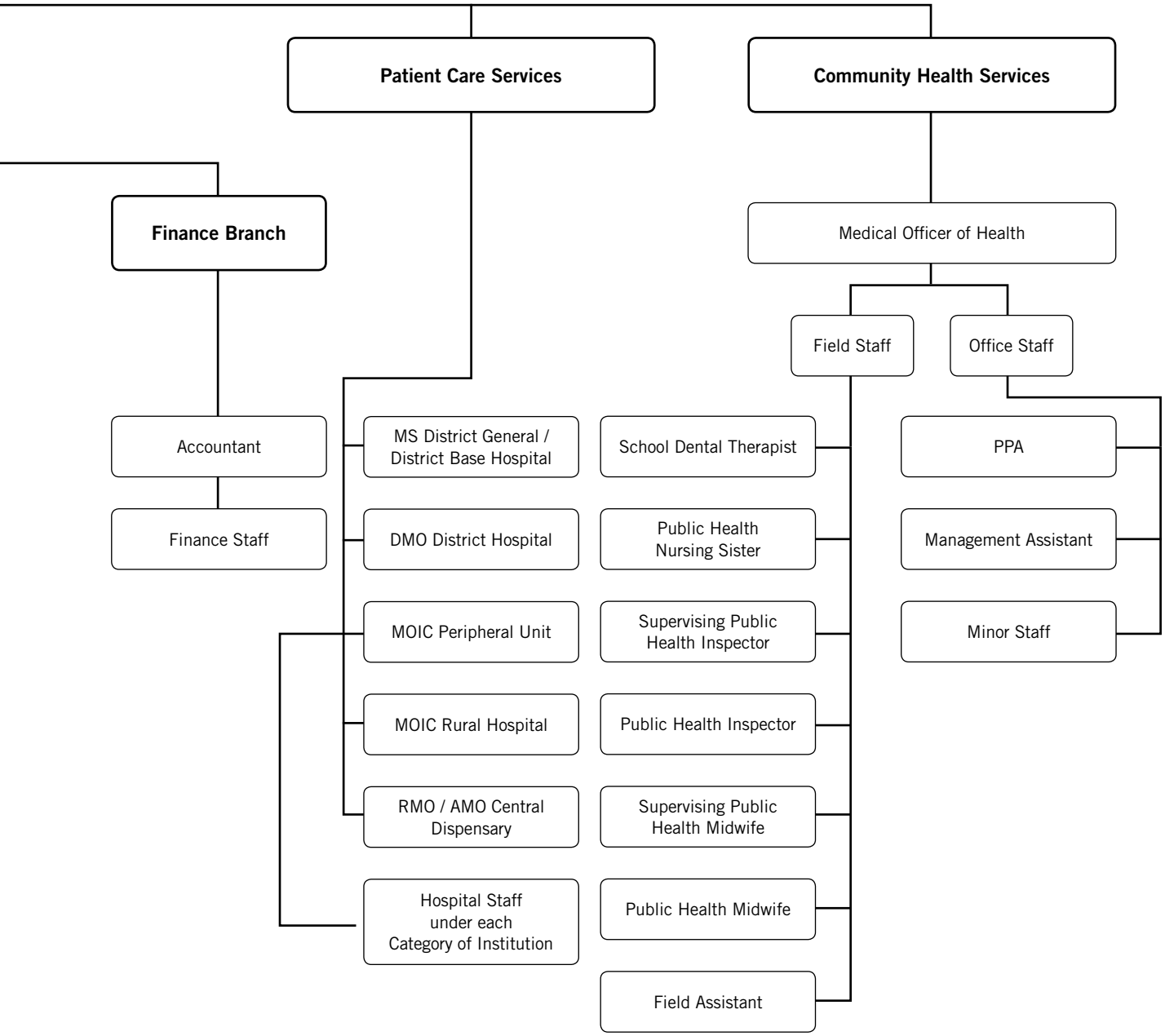
Updated May 2010
Source: Information Unit - MDPU www.health.gov.lk/OC-2010.pdf




MS Provincial Hospitals
MO Chest Clinic
Curative Care
School Dental Therapist
Field Staff
A.M.C. & A.F.C.
DMO District Hospital
RMO/AMO Rural Hospital
Hospital Midwife Maternity Homes
MO Peripheral Unit
RMO/AMO Central Dispensary & Maternity Homes
RMO/AMO Central Dispensary
Branch Dispensary
Visiting Stations

APPENDIX 4: ORGANISATION CHART FOR HEALTH SERVICES UNDER REGIONAL DIRECTOR




Patient Care Services
Community Health Services
Finance Branch
Medical Officer of Health
Field Staff
Office Staff
Accountant
Finance Staff
MS District General / District Base Hospital
DMO District Hospital
MOIC Peripheral Unit
MOIC Rural Hospital
RMO / AMO Central Dispensary
Hospital Staff under each Category of Institution
School Dental Therapist
Public Health Nursing Sister
Supervising Public Health Inspector
Public Health Inspector
Supervising Public Health Midwife
Public Health Midwife
Field Assistant
PPA
Management Assistant
Minor Staff

APPENDIX 5: DUTIES OF A MEDICAL OFFICER OF HEALTH

Duties Of The Medical Officer Of Health

(Manuel of the Dept. of Health Part IV)

a. Is in-charge of all activities, which he plans and direct.
b. Supervises and controls the work of the entire personnel.
c. Establishes cordial relations between the people of the area and the health unit personnel.
d. Makes initial health survey and special surveys of the area and prepares programmes of work based on findings of the survey.
e. On assuming charge of an area that has already been surveyed, reviews work on existing reports and visit area and prepare programmes based on findings of review.
f. Prepares advance programmes.
g. Arranges all health educational work.
h. Presides at staff conferences.
i. Prepares and forwards reports (weekly/monthly quarterly and yearly.
j. Makes diagnosis of communicable diseases in consultation with medical officers and private practitioners.
k. Gives inoculations, prescribes for mass treatment of Ankylostomiasis and supervises vaccinations.
l. Keeps accurate records of morbidity including communicable diseases and makes studies.
m. Conduct Maternity and Child Welfare and special Clinics.
n. Carries out school medical inspections and arrange for treatment of defects.
o. Carries out medical inspection of Estates in his area, or those assigned to him.
p. Supervise the work of:
    a. Maternity home
    b. Rural hospitals and dispensaries in-charge of R.M.P./A.M.P.
q. Maintains diaries and score cards (his own, P.H.I., P.H.N.S., P.H.M. up to date).
r. Acquaints himself with all parts of his health area by frequent personal visits.
s. Is responsible for discipline of his staff.
t. Carries out research and scientific investigation.
u. Integrates curative and preventive health work.
v. Organises and directs health education work in the area.

APPENDIX 6: MEDICAL SCHOOLS IN SRI LANKA

University of Colombo, Faculty of Medicine
http://www.cmb.ac.lk/
P.O. Box 271, 25 Kynsey Road, Colombo 8
Tel: +94 1 695 300
Fax: +94 1 691 581

University of Jaffna, Faculty of Medicine
http://jaffna.tripod.com/fmedicine.html
Adiyapatham Road, Kokuvil, Thirunelvely, Jaffna
Tel: +94 21 238 38

University of Kelaniya, Faculty of Medicine
http://www.kln.ac.lk/
P.O. Box 6, Thalagolla Road, Ragama
Tel: +94 1 958 219
Fax: +94 1 958 337

University of Peradeniya, Faculty of Medicine
http://www.pdn.ac.lk/med/
Peradeniya 20400
Tel: +94 8 388 315
Fax: +94 8 232 572

University of Ruhuna, Faculty of Medicine
http://www.ruh.ac.lk/Uni/medicine/Medicine.html
Karapitiya, P.O. Box 70, Galle
Tel: +94 9 348 01
Fax: +94 9 223 14

University of Sri Jayewardenepura, Faculty of Medicine
http://www.sjp.ac.lk/
Gangodawila, Nugegoda
Tel: +94 1 852 695
Fax: +94 1 852 604

APPENDIX 7: DUTIES OF A PUBLIC HEALTH MIDWIFE

Duties Of The Supervising Public Health Midwife

1. Administrative Requirements

(i) Hours of work

Week days	07.00 am – 08.00 am	Office work
	08.00 am – 12.00 noon	Field work
	12.00 noon – 02.00 pm	Lunch Interval
	02.00 pm – 05.00 pm	Field Work
Saturdays	08.00 am – 01.00 pm	Conference at MOH Office/ Local Conferences/ Field Work

(ii) The supervising Public Health Midwife shall at all times while on duty be in full uniform. The uniform be made according to the approved style.

(iii) Shall maintain a General Diary and make all relevant entries daily according to the instructions provided by the Ministry of Health.

(iv) SPHM shall reside at her approved central station in the area assigned to her. Accommodation should be provided at the office of the MOH/DHO to maintain her office. She should maintain her office in a medical institution wherever possible or a suitable location approved by the MOH of the area, if her central station is not the same as the location of the Health Office. Her office shall be available during working hours for inspection by her supervising officers.

(v) Shall not accept cash or gifts in any form as payment for services rendered by her.

(vi) She shall work under supervision and guidance of the MOH/DHO/Tutor Public Health (at the training centres) and the PHNS of the area.

(vii) She shall maintain the following records in her office.

<u>On the wall</u>

a. Map of the area according to instructions.
b. Approved monthly advance programme.
c. List of Public Health Midwives under her supervision with their respective population, number of houses and number of eligible families. Shall update this data annually.
d. Record of vital statistics for the MOH area and RDHS Division Birth rate, Death rate, Infant Mortality rate and Maternal Mortality rate.
e. Record of the MCH/FP clinics of her area, dates of clinic and Officer conducting the clinic.

<u>On the table</u>

a. Inventory and Department Instructions for Supervising Public Health Midwives.
b. General Diary.
c. Inspection notes File-A separate file should be maintained for each PHM.
d. Special Activities File
e. MCH/FP data file

2. Duties

(i) Shall work according to an approved advance programme.

(ii) Shall help MOH/DHO and PHNS in planning and organization of health activities in the area - eg

a. Shall identify the problems and service needs of the PHMM under her supervision and bring them to the notice of the PHNS and MOD/DHO of the area.

b. Shall ensure that she has correct addresses of all the PHMM in area together with information on date of appointment to present area; Date of passing EB Examination on Date of Eligibility for EB Examination; Certificate of Proficiency in IM injections and Administering of childhood immunization.

c. Shall ensure that:

- All PHM prepare and work according to an approved advance programme.
- All PHM live in their area and have their offices in the area.
- All PHMM maintain their offices as specified.
- All PHMM have their printed forms, equipment, contraceptives and drugs.
- All PHMM maintain correct records and furnish accurate and complete returns on time.

d. Shall take steps to ensure that necessary procedures are followed in order that PHMM in her area receive their uniforms and increments on the due date.

e. Shall submit a list of stationery, equipment and drugs required by midwives to the officer in-charge through the PHNS, to enable him to place the necessary indents on the due date.

3. Guidance and supervision of PHMM of her areas

(i) Shall guide and supervise the work of all PHMM in her area, at the PHM's office; in the field and at Health Centres. Field Supervision shall include demonstration of correct techniques and procedures and discussion of problems. Random checks also be carried out in the field to establish validity of entries made by PHMM in the respective records and returns. The SPHM should visit more often those midwives whose work is unsatisfactory. Reports of inspections should be prepared in triplicate. Two copies sent to the MOH through the PHNS. The MOH/DHO will with his endorsement forward one copy to the PHM concerned while the other is filed in skeleton file of the respective PHM. The 3rd copy will be retained in file by SPHM for follow-up action.

(ii) Shall ensure that PHMM perform their duties satisfactorily in relation to quantity as well as quality. Eg. Home visiting, Registration of ante-natal mothers and infants; Home deliveries and maintenance of aseptic procedures during delivery; Post partum visits; Immunization; Family Planning: Health Education and other activities.

(iii) Shall supervise and guide PHMM to organize and maintain the clinics in her area. She will visit clinics according to pre-arranged programme or according to needs identified by MOH/DHO/PHNS.

(iv) Shall check midwives returns. All returns received at the Health Office from PHMM should be given to the SPHM for the preparation of a consolidated return for her area. This return should be given to the PHNS to compile the returns for the MOH area. In absence of a PHNS the SPHM shall prepare a consolidated return for the whole area and submit it to the MOH/DHO.

(v) Shall complete quarterly appraisal forms of all PHMM in her area and submit to MOH/DHO through the PHNS. Completed appraisal forms should be retained in the respective skeleton file of PHM at the MOH office.

(vi) Shall be responsible for recommending leave to the midwives and for making acting arrangements in agreements with the PHNS. All leave applications should be sent to MOH/DHO through the PHNS. All leave applications should be sent to MOH/DHO through the PHNS, for approval.

4. Provision of specific services

(i) Shall check the investigations of Infant deaths and maternal deaths carried out by PHMM.

(ii) Shall attend staff conferences.

(iii) Shall check registration of births, in the area especially of cases delivered in the field by PHMM or other persons.

(iv) She shall see that PHMM pay more attention to mothers delivered by untrained personnel and deliveries without assistance and take necessary steps to prevent occurrence of such deliveries in future.

(v) Shall assist in health education work in her area at clinics, schools, maternity homes and rural hospitals, with special reference to maternity and child welfare work.

(vi) Shall guide the work of the midwives at Maternity homes and Rural Hospitals and report on work of the Midwives and the general cleanliness of the rural hospital and maternity home to the officer in-charge with copy to MOH/DHO.

(vii) Shall administer whenever necessary and supervise the nursing and midwifery care given by PHMM.

(viii) Shall be on call for emergencies if summoned by the Area PHMM.

(ix) Shall provide necessary advice on MCH/FP to eligible families in the area.

(x) Shall assist the health team in the prevention and central of both communicable diseases & non-communicable diseases.

(xi) Shall participate in community health programmes organized within her area with the approval of the MOH/DHO.

(xii) Shall assist in the training programmes of field health staff and other voluntary health workers with the approval of the MOH/DHO.

(xiii) Shall carry out any other instructions given by the MOH/DHO and by the department from time to time.

APPENDIX 8: DUTIES OF A PUBLIC HEALTH NURSING SISTER

Duties of the Public Health Nursing Sister

The main duties of the PHNS would comprise the following:

- Planning & Organisation of Health Activities in her area.
- Guidance, supervision and performance evaluation of Public Health Midwives in her area.
- Monitoring and Evaluation of Health activities and supervision of the health information system in respect of MCH/FP
- Staff development and training
- Provision of specific services
- Simple research

1. Administrative Requirements

(i) Hours of work

Week days	7.00 am – 08.00 am	Office work
	8.00 am – 12.00 noon	Field work
	12.00 noon – 2.00 pm	Lunch Interval
	2.00 pm – 5.00 pm	Field Work
Saturday	08.00 am – 01.00 pm	Conference/MCH Clinics/MOH Office
Sunday	Off day but on call duty.	

(ii) The Public Health Nursing Sister shall at all times while on duty be in full uniform. The uniform be made according to the approved style.

(iii) Shall maintain a diary and made all relevant entries daily according to the instructions provided by the Ministry of Health and shall submit the diary to MOH for perusal and signature monthly.

(iv) Shall maintain her office at the Health Unit (MOH Office) or suitable place within her area approved by MOH. This office shall be available for inspection during working hours by her supervising officers.

APPENDIX 9: DUTIES OF A PUBLIC HEALTH INSPECTOR

Duties And Responsibilities Of Public Health Inspector (Range)

General Circular No: 29th September, 1989

1. Duties of Public Health Inspectors (Range)

General

(a) Shall gain the confidence and cooperation of the people of his assigned area;

(b) Shall within three months of assuming duties in the area carry out a survey of the area and write a report according to departmental instructions, and prepare a programme of work for approval of the supervising officer.

Control of Communicable Diseases:

(c) Shall investigate cases of communicable disease, keep contacts under surveillance and take appropriate action to prevent the further spread of diseases.

(d) Shall carry out immunization programmes in schools according to departmental instructions, and assist in immunization at clinics when instructed by the supervision officer;

(e) Shall assist Specialized Campaigns in their disease control activities when called upon to do so;

(f) Shall assist in tracing contacts of leprosy, tuberculosis and sexually transmitted diseases, and in training of treatment defaulters.

(g) Shall visit medical institutions in his area and ascertain the communicable diseases treated at these institutions and take appropriate action.

(h) Shall study the mortality and morbidity statistics of the area and submit proposals to the supervising officer.

Housing

(i) Shall regularly inspect houses and advise on the requirements of sanitary latrines, water supply, refuse disposal light and ventilation and maintenance of a home garden, and ensure that improvements are carried out.

(j) Shall report on building applications, carry out inspections of new buildings under construction, and make recommendation on the issue of certificates of conformity for completed buildings.

(k) Shall report and take action on unauthorized buildings.

Sanitation

Shall get latrines constructed, and recommend financial assistance, where appropriate, under the Aided Scheme of Latrine Construction.

Water Supply

(l) Shall supervise the maintenance of public water supplies and ensure proper disinfection.

(m) Shall supervise the maintenance of public water supplies and ensure proper disinfection.

(n) Shall send water samples for bacteriological and chemical analysis.

(o) Shall inspect private and public wells and ensure that improvements are carried out.

Refuse disposal

(p) Shall supervise the scavenging service of local authorities and ensure collection and proper disposal of refuse.

(q) Shall undertake fly and mosquito control, ani-rat work and the abatement of nuisances of public health importance.

Rabies Control

(r) Shall take action to ensure vaccination of dogs against rabies and the eradication of stray dogs.

Food Safety

(s) Shall carry out a survey of all food handling establishment in his area, and regularly inspect food-handling establishments and advice on improving their sanitary conditions.

(t) Shall carry out the responsibilities of an Authorized Officer under the Food Act;

(u) Shall pass animals for slaughter when called upon to do so by the supervising officer and ensure proper sanitation of slaughter houses:

Sanitation of Medical Institutions

(v) Shall inspect fairs, markets and festivals and ensure maintenance of proper sanitation.

(w) Shall supervise the sanitation of medical institutions and submit reports to the medical officer in-charge of the institution.

School Health Work

(x) Shall carry out a school health survey according to departmental instructions and formulate a

programme of work.

(y) Shall assist the Medical Officer of Health/District Health Officer in carrying out School Medical Inspections and carry Medical inspections himself when directed to do so.

(z) Shall carry out immunizations and work treatment in schools.

Occupational Health (Including Estate Health)

(aa) Shall inspect all factories and work-sites in his area and identify any health hazards and advice on remedial measures.

(bb) Shall inspect all estates in his area and advise on environmental sanitation and the control of communicable diseases.

Sanitation during Disasters and Epidemics

(cc) Shall organise and supervise health activities related to environmental sanitation and the prevention of communicable diseases during disasters and epidemics.

Records and Reports

(dd) Shall maintain records and submit reports as required by the supervising officer according to departmental instructions.

Health Education

(ee) Shall plan and implement a programme of health education in his area and ensure community participation in health activities.

Team Work

(ff) Shall work and maintain cordial relations with the public health nursing sister and public health midwife of the area as a member of the health team.

(gg) Shall carry out any other duties assigned to him by his superior officer.

APPENDIX 10: ASRH CONTENT AND COMPETENCIES IN THE SCHOOL CURRICULUM GRADES 6-13

	GRADE	ASRH RELATED CONTENT
Life Competencies & Citizenship Education	6	**3.2** Building up healthy relationships through effective communication **6.2.6** People who help us Grama Nilandari, Samurdhi officer, Police officer, midwife, public health officer, postman, voluntary organizations (NIE 2006)
Health & Physical Education	6	**Competency 9:** Adapts to an efficient lifestyle while maintaining the wonder of the body well. Activity includes discussion of the reproductive system with a focus on propagation of the species. Growth and development but only height weight and movement from childhood interests and controlling quick tempers **Competency 11:** Facing Challenges successfully for the Wellbeing ▪ Let us be bold Let us live a disease free life includes Abstinence from alcohol & cigarettes, avoiding stress, daily concern of the cleanliness of their genitalia. Mention if infectious disease such as AIDS **Competency 13:** Leads a happy life successfully facing obstacles in day-to-day life. Activity involves brainstorming issues teacher materials that include scenarios of sexual abuse & pornography (NIE 2007)
Science	6	**Competency 1:** Observes the world as a scientist **Competency 3:** Investigates animals diversity (NIE 2007; NIE 2007) ▪ Growth and reproduction as feature of living beings. "Baby animals are produced by animals. This process is known as reproduction." Alongside picture of Polar bear and cubs (EPD 2009)
Health & Physical Education	7	**Competency 2:** Satisfies Human needs for a Healthy Life. ▪ The need for love and protection **Competency 9:** Chart of reproductive system to be included although not included in systems in (NIE 2007) "smoking is the main cause for sexual incompatibility" (p 181) **Competency 11:** Facing Challenges successfully for the Wellbeing. Includes "disease caused by touch, infected blood and unprotected sex" HIV Hepatitis B, gonorrhea, syphilis symptoms and prevention **Competency 13:** Leads a happy life, successfully facing obstacles on day life. Abuse and exploitation included and a suggestive case study inferring the rape and murder of a girl and encouraging children to seek help & prevent vulnerability
Science	7	**Competency 3:** Investigates the pattern in the animal body to perform life functions. Includes the human reproductive system of 5 systems in 120 minutes time allowance in 72 hr. program (NIE 2008) ▪ Body as machine ▪ Organizational patterns in body structures of animals includes reproduction 1 page with basic picture of male and female organs (EPD 2009)
Life Competencies & Citizenship Education	8	**Competency 6:** Use Public Services effectively– includes overview of health service
Health & Physical Education (EPD 2008)	8	**Competency 1:** Contributes to building up of a Healthy Society. **1.1** Contributes to the maintenance of the Health of the school ▪ Contribution of the school community. ▪ Health Development Programs ▪ Services that can assist. ▪ Health Clubs ▪ Health Services ▪ Community Counselling Committees ▪ Other relevant Ministries ▪ Co-curricular Activities

Competency 2: Satisfies Human needs for a Healthy Life.

2.1 Leads a Healthy Life while satisfying the Higher Human Needs

- Higher Human Needs.
- Self-esteem
- Self-Actualization
- Factors influencing one's self esteem.
- Completeness of skills
- Physical skills
- Mental skills
- Social skills
- Aesthetic skills
- Moral skills
- Skills of emotional balance
- Re-enforcement
- Acceptance
- Approaches to the fulfilment of self-esteem.

Competency 9: Adapts to an efficient life style while maintaining the Wonder of the Body.

9.1 Leads a Happy life maintaining the wonder of the reproductive system

Importance of maintaining the wonder of the reproductive system I Continuity of Life

9.2 Leads and efficient life preventing obstructions to the wonder of the reproductive system

Obstacles to the wonder of the reproductive system

- Delinquency
- Abuse
- Myths and Misconceptions
- Correct Education
- Correct Social Values
- Correct Habits

Competency 11: Faces challenges successfully for wellbeing

11.1 Maintains reproductive health for the sake of wellbeing.

- Main changes at adolescent stage
- Facing these changes successfully
- Factors that affect the function of reproduction
- Hygiene and maintenance of reproductive systems
- Understanding the realities of life
- Sexually transmitted diseases including HIV/AIDS
- Physical changes
- Mental changes
- Hormones
- Social changes
- Healthy reproductive systems
- Healthy behaviour

Competency 13: Leads a happy life, successfully facing obstacles on day life.

13.1 Facing the environmental challenges of daily life with confidence

- Environmental challenges
- Accidents
- Disasters
- Deviance and abuse
- Drugs and alcohol
- Cigarettes
- Diseases
- Importance of facing challenges with confidence
- Controlling the situation
- Minimizing damage
- Taking protection

Health & Physical Education (NIE 2010)	9	**Competency 1:** Contributes to building up of a Healthy Society. ▪ Alcohol and drugs and diseases **Competency 9:** Adapts to an efficient life style while maintaining the Wonder of the Body. Activities of hormones and enzymes **Competency 11:** Faces challenges successfully for wellbeing ▪ Acts responsibly on matters of sexuality ▪ Marriage and cultural importance, legislative importance ▪ Gender ▪ Responsibility of man during pregnancy and child protection ▪ Sexual abuse **Competency 13:** Leads a happy life, successfully facing obstacles on day life. ▪ Infectious disease including HIV
Science (NIE 2010)	9	Worm and plant reproduction
Health & Physical Education (NIE 2007)	10	**Competency 1:** Contributes to building up of a Healthy Society. ▪ Patterns of health suitable for maintenance of health – including avoiding smoking an alcohol, conforming to rules, standards and regulations, correct food habits ▪ Challenges to current health conditions – including being displaced, risky sexual behaviour, alcohol, drugs and cigarettes, breakdown of interpersonal relations **Competency 2:** Satisfies Human needs for a Healthy Life. ▪ Main stages of childhood includes pre-natal stage and importance of health of mother including protection from sexually transmitted diseases **Competency 9:** Adapts to an efficient life style while maintaining the Wonder of the Body. ▪ Reproductive system **Competency 13:** Leads a happy life, successfully facing obstacles on day life. ▪ Identifying challenging situations – including sexual abuse ▪ Influencing situations on wellbeing – including minimization, prevention, first aid
Science – Biology (NIE 2008)	11	**Competency 1:** Investigates on the adaptation of mechanisms which are adapted to perform bodily functions efficiently **1.3:** investigates the hormonal process in the body – includes endocrine glands, hormones and their function, testes and ovaries, etc. **Competency 2:** Investigates on the reproduction of organisms **2.3** reproduction in human – structure and function of the reproductive system, sexually transmitted diseases i.e. HIV, Syphilis and gonorrhoea **Competency 4:** Investigates the significance of genetic material for the establishment of biodiversity **4.2** investigates the significance of genetic material for humans – includes disease i.e. Thalassemia

Health & Physical Education (NIE 2008)	11	**Competency 2:** Satisfies Human needs for a Healthy Life. Includes Needs of adolescence – physical, mental, social, spiritual **Competency 11:** Faces challenges successfully for wellbeing **11.1** Identifies the challenges of adolescences and acts towards wellbeing. ▪ Changes that take place in adolescence. ▪ Factors that influence these changes. ▪ Facing challenges of adolescence successfully. – Potentials that youth possess. – Beneficial employment of potentials. – Banned stimulant drugs – Damage that can be caused due to the use of banned stimulant drugs. **Competency 13:** Leads a happy life, successfully facing obstacles on day life. **13.1** Acts with a sense of maturity in face of physical conditions, adverse to health. Sexually transmitted diseases. ▪ HIV/AIDS. ▪ Student contribution to prevent infection.
Science – Biology Advanced level (NIE 2008)	12-13	**Competency 1:** Nature and organisational patterns of living things includes human reproduction **Competency 7:** Investigates the structure and functions of homeostasis – **7.1.8** Roles of the human endocrine system **Competency 10:** Inquiries into the reproductive system of organisms **10.1.2** Inquiries into the process of human reproduction **10.1.3** Structure and function of male reproductive system **10.1.4** Structure and function of the female reproductive system **10.1.5** Process of fertilization **10.1.6** Nutrition and development of child **10.1.7** Develop an awareness of reproductive health

APPENDIX 11: HEALTH INDICATORS FOR KALUTARA DISTRICT

Family Health Bureau 2007. http://www.familyhealth.gov.lk/kaluthara.htm

PDHS Area
Western Province

DPDHS Area
Kalutara

MOH Area
- Bandaragama
- Matugama
- Panadura
- Agalawatta
- Horana
- Bulathsinghala
- Walallawita
- Madurewela
- N.I.H.S. Kalutara
- Ingiriya
- Beruwala

Kaluthara District

INDICATORS	DATA	YEAR	SOURCE	KALUTHARA
Total Mid Year Population (000')	20010	2007	Registrar General's Dept	1111
Women in Reproductive Age Group (000')	5.44		Registrar General's Dept	
Total Number of Births	380069	2007	Registrar General's Dept	16786
Crude Birth Rate (per 1000 population)	18.99	2007	Registrar General's Dept	15.11
Total Number of Deaths	116883	2007	Registrar General's Dept	6550
Crude Death Rate (1000 population)	5.84	2007	Registrar General's Dept	5.9
Neonatal Mortality Rate (per 1000 Live Births)	8.7	2003	Registrar General's Dept	2.7
Infant Mortality Rate (per 1000 Live Births)	11.0	2003	Registrar General's Dept	4.0
Under Five Mortality Rate (per 1000 Under Five Population)	13.47	2003	Registrar General's Dept	4.97
Maternal Mortality Rate (per 100,000 Live Births)	44.3	2005	Family Health Bureau	35.2
Contraceptive Prevalence Rate (per 1000 married women)	70.0	2000	DHS	
New Acceptors Rate for Family Planning	76.5	2005	Family Health Bureau	80.1
Percentage of Teenage Pregnancy	7.7	2005	Family Health Bureau	6.0
Percentage of Mothers Registered before 8 weeks of POA	54.8	2005	Family Health Bureau	62.1
Percentage of Pregnant Women protected with rubella	91.4	2005	Family Health Bureau	96.5
Percentage of Skilled Attended Delivery	96.0	2005	DHS	
Percentage of Low Birth Rate	13.4	2005	Family Health Bureau	13.8
Percentage of Mother Received Post Partum Care during 1st 10 Days of Delivery (Out of Estimated Births)	75.0	2005	Family Health Bureau	77.1
Percentage of Infant Weighed below 3rd Centile	10.5	2005	Family Health Bureau	7.6
Percentage of Children 1-3 Years below 3rd Centile	29.4	2005	Family Health Bureau	21.2
Percentage of Children 3-5 Years below 3rd Centile	27.4	2005	Family Health Bureau	18.1
Coverage of School Medical Inspection	98.5	2005	Family Health Bureau	91
Number of functioning Well Woman Clinics	426	2005	Family Health Bureau	15
Percentage of Primi mothers	37.4	2007	Family Health Bureau	39.0
Percentage of Pregnant mothers tested for VDRL	92.1	2007	Family Health Bureau	99.6
Percentage of Pregnant mothers tested for grouping and RH	99.1	2007	Family Health Bureau	100.0

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University of New South Wales

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www.uq.edu.au/hishub

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www.ni.unimelb.edu.au

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www.wchknowledgehub.com.au

Human Resources for Health Hub

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