MEANINGFUL ADOLESCENT AND YOUTH ENGAGEMENT ON HEALTH AND WELL-BEING IN SRILANKA: GAPS AND RECOMMENDATIONS

Introduction to Youth Advocacy Network Sri Lanka

Youth Advocacy Network Sri Lanka (YANSL) is a Youth-led organization that serves the youth population in Sri Lanka. The organization was founded in 2014. Since the inception of Youth Advocacy Network Sri Lanka, several projects and programmes have been conducted by the youth volunteers of the organization. Among the many projects that were conducted by Youth Advocacy Network Sri Lanka, the project 'We Hear You' and the project 'Video Documentation of Historical and Political Trajectory of Legalizing Safe Abortion in Sri Lanka' obtain a significant place.

Project 'We Hear You' was initiated in the year 2014. The target population was people living with hearing disabilities. Under this a sign language glossary that included key terminologies that fall under comprehensive sexuality eproject ducation and several advocacy programmes on sexual and reproductive health and rights were conducted for both the teachers and the students of Ratmalana School for the Deaf and a disability-friendly website was created. Click here to visit the website.

Video documentation of the Historical and Political Trajectory of Legalizing Safe Abortion in Sri Lanka is another significant project initiated in the year 2019 by Youth Advocacy Network, Sri Lanka. Six videos were created that captured the various attempts taken by doctors, researchers, and activists to legalize safe abortion in Sri Lanka. The videos can be viewed by clicking here. During the second phase of the project, a youth consultation was conducted. The objective of the youth consultation was to showcase the videos that were produced and to raise the awareness of the participants on the issues surrounding the lack of access to safe abortion services in Sri Lanka. Finally, during the third phase of the project, five stories of young girls who had faced difficulties in accessing sexual and reproductive healthcare services including access to safe abortion, during the COVID-19 Pandemic were documented in the form of social media posts.

The year 2020 was challenging for everyone globally. With the onset of the COVID-19 Pandemic every individual, community, company, and organization had to shift their work to the online space. Youth Advocacy Network Sri Lanka shifted its advocacy campaigns to the online space. The organization conducted advocacy campaigns on Facebook, Instagram and Twitter and can be viewed by clicking on the respective social media sites.

Objectives

As part of the Southeast Asia Youth Health Network (SYAN) Youth Advocacy Network Sri Lanka published this report with the objective of strengthening the Adolescent Health & Wellbeing Advocacy in Sri Lanka. This report was produced as an output of a consultation hosted with stakeholders working towards AHWB in Sri Lanka to understand the current gaps in the advocacy process. This report acts as a resource for advocates working towards AHWB agenda to provide support in strengthening their advocacy efforts.

Date: 3rd of December
Time: 10.00 AM- 11.30 AM
Venue: Zoom
Participants

- Sarah Soysa – National Programme Analyst – UNFPA Sri Lanka
- Araliya- Advocacy Coordinator – World Vision Sri Lanka
- Dr. Chiranthika Vithana- Family Health Bureau – Ministry of Health Sri Lanka • Buddhini Athukorala
- Lasantha Premachandra- Manager -Advocacy and External Engagement – World Vision Sri Lanka
- Dr. Manjula Danansooriya- National Programme Officer WHO Sri Lanka
- Hafsah Muheed – Moderator – Youth Advocacy Network Sri Lanka

The discussion began exploring if the current youth policy of Sri Lanka which prevailed intime being, was sufficient in capturing the needs of Adolescent Health & Wellbeing (AHWB).Dr. Chiranthika mentioned the fact that from 2016 Sri Lanka has a youth policy and youthhealth policy which covers a broad area promoted by the health sector. She further statedthat those were strategic plans but the need for refining exists to introduce accountability.

This was followed up with exploring ways to refine critical gaps in the currently designed strategies. This emphasized the need for youth involvement in advocating adolescent health and wellbeing and touched on the need of engaging in youth empowerment across differentplatforms using different methods to ensure they are part of the advocacy process.

Dr. Chiranthika mentioned, though the national strategic plan on adolescent health, youthpolicy and youth health policy are currently being exercised, the need of reconstructing thecurrent process to empower youth is the prevailing need. She mentioned that the Ministry ofHealth has suggested several steps to increase youth involvement, and that there are levelsof youth participation which can be handled by youth and there are levels which cannot behandled by the youth such as being providers of health services. She clarified the statementby saying though that kind of services must be handled by experts, the need for engagement of youth in advocacy is high. She also mentioned the need to understand the extent of participation by youth at various levels in the advocacy process is the most critical starting level of empowering young people to advocate their health and wellbeing as there are many facets in the system itself. Dr. Chiranthika clearly mentioned that to bridge these gaps youth must be aware of the status of AHWB and identify the need of empowering themselves andwork towards generating ideas and strategies to get involved in the process. She shared with the current context, in AHWB advocacy, young people are the least proactive due to the absence of awareness.

Mr. Lasantha highlighted the criticality of facilitating a needs assessment on theunderstanding of AHWEB health services among youth by conducting a gap analysis and on available services and the strategies that are in place. He also stated that gap analysis ismuch needed to drive youth led advocacy. Further he mentioned that for youth mobilization in driving the AHWB agenda, focusing on evidence-based advocacy is vital.

During the discussion, the barriers and gaps that lead to absence of youth mobilization was explored. Mr. Lasantha mentioned that young people do not prioritize youth and adolescent health as prominent issues due to their thinking patterns and Sri Lankan context. He emphasized his views on the duty of mobilizing youth on AHWB by creating awareness ontheir AHWB rights, existing resources, and gaps. He shared that he believes it is this lack of awareness that prevents young people from advocating for AHWB.As the conversation explored the absence of resources and restricted access to evidencedisconnects youth from evidence based, Mr. Lasantha mentioned that there is an absence of resources as well as information. He stated that youth understand only directly available information which they can access and as they lack an understanding about standard information on health services, the absence of the gap rather the existence of gap in AHW Brights and services is not visible to them. He stated that if the optimal level is not comprehended, they accept it as it is available. He quotes "we have to open their eyes and visualize these services, then only they will realize the gap and as well as because of the gapshow it is badly affecting the general public youth as well as adults." He shares an example.The impact of malnutrition for under 5-year-old in Sri Lanka is a prevalent issue and it is yetto be understood by the youth to raise and advocate on behalf of the voiceless infants. He shares that this can be only done if the gap is bridged between youth groups and health services. Dr. Chiranthika agreed with Mr. Lasantha; on the lack of awareness about services and possibilities is an outlier resulting in youth not accessing the services and not being anactive participant in advocacy.

To bridge these gaps, Dr. Chiranthika mentioned the need of implementing multiple modes of capacity building which must be initiated from several points, where resource hubs such asschools, training centers, workplaces, families and other networks like government organizations and non-governmental organizations must collaborate and be utilized effectively.Dr. Manjula supported the ideas of Dr. Chiranthika by emphasizing the need of using several strategies starting from schools. She mentioned that the MOH system does not reach to itsfull capacity as the public is unaware of it until someone gets pregnant on available public health services, so the need of publicizing about the services offered by the public healthstaff to adolescent youth and school children is a priority that needs to be fulfilled. She further mentioned that lack of knowledge on their rights and available services is a gap madeout by the absence of the grassroot information sharing by the health sector. She stated that the need to actively engage in publicizing public health services by the health providers is essential. She took her ground about the use of digital modes as a must as it is popular among youth. *"We must use these avenues to publicize the services available, about theirrights, and about the right to access services since the flow of education from school comesfrom a passive angle. We do not demand our needs as young people; I mean we have ahesitancy to express our requirements and needs. Hence, we live in a suppressed mode throughout school as students and this can be challenging for us when we must change our attitude and behavior. But we must try various options; not only focusing on raising awareness but also upskilling on being able to speak up, especially on assertive communication. Youth need to request their rights from health providers in a healthy manner rather than demanding their rights"* said Dr. Manjula.

She also emphasized the need to optimally use other settings such as youth council, youth core clubs, vocational training institute and other formal settings. She said that she has seen some of the awareness programs and projects which are temporary, ad hoc, and not well sustained. To overcome that issue, she mentioned the need for an updated system to publicize their services and to organize capacity building activities that come with a long-range sustainability. The moderator shared that the above approach is critical in breaking stereotypes of stakeholders engaging in the advocacy process.

The discussion then prompted the question if advocacy of AHWB is inclusive. Dr. Manjula shared, ''even though we want to include people with hearing and visual impairment sometimes when it comes to service provider angle in the health sector we are very challenged from lack of human resources, and that is one big challenge in getting marginalized and vulnerable adolescence and young persons into our inclusive approach. For example, very few people know sign language; very few people know how to translate our materials into braille in the public sector. So that is an area where even though we wanted to reach, our reach is challenged by those resource constraints''.

Dr Chiranthika said that the involvement of most sectors is needed, including district secretariat, divisional secretariat, youth ministry, youth core clubs, and youth networks in the various localities to ensure inclusion & accessibility. She further agreed on the view of Dr. Manjula by saying that though visually impaired and hard hearing people need to have their rights regardless of these gaps. To fill that, the need of strengthening volunteerism among youth is high and both are to benefit from it. She stated her view on the gap on opting out the marginalized community from the service providers side needed to be addressed with available resources.

The idea of avoiding the complexity of the process by designing a proper mechanism rather than amending faults was identified as the current need raised in the discussion. Mr. Lasantha highlighted the need of including DPOs, Disability People Organizations and CBOs in district level by facilitating a need analysis to identify their real needs to enhance the accessibility to services. He added that as the ministry of social welfare is having a better rapport with the marginalized community and disability centers, he suggested the need for collaborating with them on advocacy processes.

Dr. Manjula seconded the idea of the other panelist by elaborating about the WHO workwhich requires a quota from youth in the technical and designing processes of AHWB initiatives. She mentioned that though there is a quota for youth in the Technical advisory committee on AHWB run by the Family Health Bureau, young people are not enthusiastically taking part in the decision-making process. She shared the need for ensuring young people are nominated and follow through with their participation. “Even though they got thechance, youth are not actively joining in their capacity to make it work out, youth have tounderstand their responsibility of getting the opportunity and use it for better outcome” said Dr. Manjula.

Then the discussion navigates through the need of identifying active and inactive stakeholders who are youth and beyond the youth. Dr. Manjula said that the idea of being active and inactive is subjective as stakeholders are practicing their own way of work, sheexplained while some stakeholders who work in the field of mental health do follow their mandate; an example would be ‘ADIC’ and ‘youth action network’ who are actively working on the field of substance use but when it comes to other youth issues they are inactive” saidDr. Manjula. She insisted on the inability of categorizing as it is subjective and dynamic.

The need and the right way of the holistic and the multisectoral approach of collaboration inadvocacy was brought to the table of discussion. Dr. Chiranthika shared that in the current context, it is only available at the national level as district and divisional level is not able topractice that kind of approach. She explained that idea by talking about the Technical advisory committee on young people's health as an example to the multisectoral approachthey have sustained at national level, though they have advised the district and divisional level to adapt that, they are unable to work it out.

Sarah shared that there are great tools and materials available with youth action hubs which can be used in the country specially looking at multisectoral collaboration, youth adult partnership and SRHR that is also adapted to local context.

Dr. Manjula said that though the national level has set the example by using the multisectoral approach by sustaining the technical advisory committee, yet the district and divisional level voice down to individual attitudes. Further she mentioned that it may be due to the negative experiences which they had previously by working with various entities, that they want to be confined to specific activities rather than reaching a multisectoral angle. She insisted that the number and the type of stakeholders depend on the context of the work. She gave some examples by saying that it is not possible to map out comprehensive or suitable stakeholders as it is context specific.

As AHWB is a vast area, the discussion then prompted identifying areas which have been touched in the advocacy process and how to include the excluded areas into the advocacy process. Sarah shared that youth feminist leadership and intergenerational work is excluded. Mr. Lasantha mentioned that they could not go for a blanket approach as issues vary to different areas so that they need to adapt a very customized angle to approach.

Dr. Manjula voiced her idea on how to bridge the gap of youth being accountable and involved at grassroot level and regional level by mentioning that youth must be empowered through repeated awareness and skill building. She said that it must start from schools, and it should set an approach, which must balance in between formal and community-based settings like youth federations and youth council.

While talking about the gaps which prevent a smooth transition or implementation, Mr.Lasantha mentioned that due to the disconnect, youth move away from advocating themselves. He explained that there are entities like the Ministry of Health (MOH) and Youth Development Officers who are directly connected with the youth clubs. He said that it ismuch needed to connect services on youth and adolescent health with MOH and these officers from the District Secretariat. He also shared that the lack of interconnectivity has made a huge gap even at the National level. Dr. Chiranthika did not agree and insisted thatthough there is a need to strengthen it more, the technical advisory committee has linked the entities related to the youth at national level including youth ministry, sports ministry etc. She also shared that local MOH offices, and other district level officials are expected towork together, to strengthen that there are forums and guidelines that have been shared, yet in practicality, the situation is different from the expected level.

Sarah highlighted the lack of leadership positions for youth. Even the youth officers etc, themselves are not young people. To bridge this, youth-adult partnerships need to be strengthened.

The discussion then focused on multisectoral awareness on national commitments, collaborative approaches to translating commitments to actions, accountability tools andstructure in place and communication of progress in the context of national commitments on AHWB. Mr. Lasantha said the need for MOH must identify the ways of interacting with otherministries and departments to ensure multisectoral approaches are critical. He shared theministry of health is accountable for implementing commitments. Dr. Chiranthika added thatthough some parties must take the leadership, every other ministry needs to have the duerecognition of national commitments but in divisional and district level there are visible gapswhich need to be addressed. She stated that though there is some collaboration, absence ofyouth led action is visible.

Mr. Lasantha shared an example of how the ongoing national nutrition action plan has a multi sectoral aspect to it. He said that though he is unaware about the extent it included youth and adolescent nutrition needs, the plan itself is an integrated approach and multi sectoral action plan at national level which is led by the ministry of health. He further mentioned that as they were trying to develop a district level multi sectoral action plan as well. He shared that it must be suggested to include youth and adolescent nutritional needs to the existing action plan and advocate for the implementation of it.

Young people being absent in the advocacy process compared to the other stakeholders in advocating for their own rights and wellbeing was highlighted throughout as a critical gap. When exploring accountability structures and tools, the question that arose was whether young people are the only accountable party in this process. Dr. Chiranthika mentioned that all should be accountable and young people are only one sector and that includes MOHs, divisional secretaries, other partner organizations, educational sector, and youth ministry.

Mr. Lasantha shared that he believes lead accountability goes to the Ministry of Health and all others must be active in accountability. Youth alone cannot hold MOH accountable. Other parties for example, parents from community groups also must hold MOH and the government accountable. Dr. Chiranthika shared that Ministry of Social Welfare and Ministry of Youth must be accountable in focus areas such as sexual and reproductive health rights (SRHR) and the absence of social empowerment in that context. Only then can the health sector move to a level covering the health process and certain other aspects must be covered by other parties.

The conversation then focused on communication of advocacy & action plans and progress on commitments. It was highlighted by participants the very absence of the above-mentioned communication key gap in the advocacy journey of AHWB in Sri Lanka. Because of the lack of communication, advocacy initiatives from the community level are absent. While there is information at the government level, the accessibility of that information at the community level was identified as a gap. With the absence of information on available services being absent in terms of what are the rights, what are international standards, who is accountable. The advocacy in AHWB should focus on eliminating and mitigating this gap.

The necessity of including the Youth and Adolescents health related information to the education curriculum was raised and Mr. Lasantha mentioned that though he is unaware of recent updates there are several SRHR components and health related information included to the syllabus of science. He insisted that the proportion must be questioned as it seems insufficient. He explained the need for refining the curriculum and including the necessary areas to educate the technical aspects and services available.

The discussion then focused on the delivery of these updated curriculums, since capacity building and empowering young people was seen as a key method to innovate the advocacy process raising the question; are communication of progress and accountability measure's part and parcel of the AHWB advocacy process currently in Sri Lanka. A gap that also was identified was while AHWB strategies were being translated into action plans, accountability of the advocacy processes.

Participants shared that the National Institute of Education (NIE) should be included in the process to ensure quality of delivery. The discussion also raised concerns of teachers skipping reproductive health and this could be due to lack of confidence or technical capacity to deliver that lesson to students. Hence educational authorities must be included in the advocacy process.

Since the area of technical capacity was discussed, the need for accounting in the advocacy process and designing action plans for it; an example would be if the teacher is not equipped to deliver, partnering with the local MOH office so that awareness and information is rightfully shared with the youth of the country. Mental health and reproductive health are not focused on enough in terms of AHWB. The need for sufficient conversation on holistic and proactive advocacy focused on mental health, non-communicable diseases, fitness and exercising also arose as a gap in AHWB advocacy.

Participants shared that if mental health is looked at, each school is to have a counselling teacher as per the standard, but it is not available in every school. Some schools while they may have a teacher may not have facilities set up to deliver that service. Some schools just nominate a teacher who is available. This happens to be the tendency. There is also a need to explore how much schools are linked with district level hospitals because there is a mental health community available there.

In the current context of the ongoing pandemic the evidence clearly shows that children and youth coming back to school are showcasing different types of mental health-related psychosocial issues/needs. The gap on who is going to address those needs and how far our schools are linked with mental health services is a key question. So, there is a need to focus on this area apart from the sexual reproductive health.

Participants also shared that there is a gap where students do not engage with counselling teachers because they do not have that trust and confidence. There is a need for school level counselling maintaining confidentiality and other ethics of counselling. There are some sources which they may use for support. So, there is some form of information and awareness.

The discussion then focused on bridging the gap, in terms of the advocacy process for various stakeholders and the areas identified under AHWB as critical. The resources needed to support evidence-based advocacy and how such resources can be designed, created, or supported or provided was highlighted and how it changes at a national, regional and community level. The absence of communication on national commitments; using modes such as digital campaigns which would increase access of information on advocacy processes was also highlighted as a gap. This also raised the question of reaching a diverse audience in dissemination of information and in terms of mobilization, is it the same group of young people that are being mobilized. The conversation also highlighted that their young people are not even aware of youth services such as the national youth council & youth clubs. Inability to reach that audience was also highlighted as a gap.

The critical gaps that were identified in AHWB advocacy was absence of accountability measures and resources for it. Participants shared that there are researchers particularly productive, research qualitative and quantitative. In terms of funding AHWB is not a priority in the current context. The need for advocacy on allocating funding on AHWB was highlighted.

Participants shared that one of the best ways to address that gap, is mobilization. It is very much needed to mobilize each stakeholder on AHWB advocacy, especially on raising awareness on available services which would help young people, so they are able to understand the gaps. Engagement relating to communication is another strategy that would support bridging the gaps of AHWB advocacy processes.

Gaps Highlighted

- The need of reconstructing the current process to empower youth is the prevailing need
- Lack of awareness on current AHWB advocacy status as a country by the youth of Sri Lanka
- Young people do not prioritize youth and adolescent health as prominent issues due to their thinking patterns and Sri Lankan context
- Lacking an understanding about standard information on health services, the absence of the gap rather the existence of a gap in AHWB rights and services is not visible to them
- Lack of interconnectivity among stakeholders in AHWB advocacy process
- Lack of leadership positions for youth
- Absence of accountability in AHWB advocacy processes
- The need for sufficient conversation on holistic and proactive advocacy focused on mental health, non-communicable diseases, fitness and exercising also arose as a gap in AHWB advocacy

Recommendations

- Mobilizing youth on AHWB by creating awareness on their AHWB rights, existing resources, and gaps
- Implementing multiple modes of capacity building which must be initiated from several points, where resource hubs such as schools, training centers, workplaces, families and other networks like government organizations and non-governmental organizations must collaborate and be utilized effectively.
- Publicizing about the services offered by the public health staff to adolescent youth and school children
- Youth-adult partnerships need to be strengthened.
- Comprehensive sex education to be delivered to young people during schooling
- Educational authorities must be included in the advocacy process.
- Engagement relating to communication