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ReBUILD Consortium

Mental health and psychosocial support service provision for adolescent girls in post-conflict settings: a culturally sensitive response

Country report: stage 2

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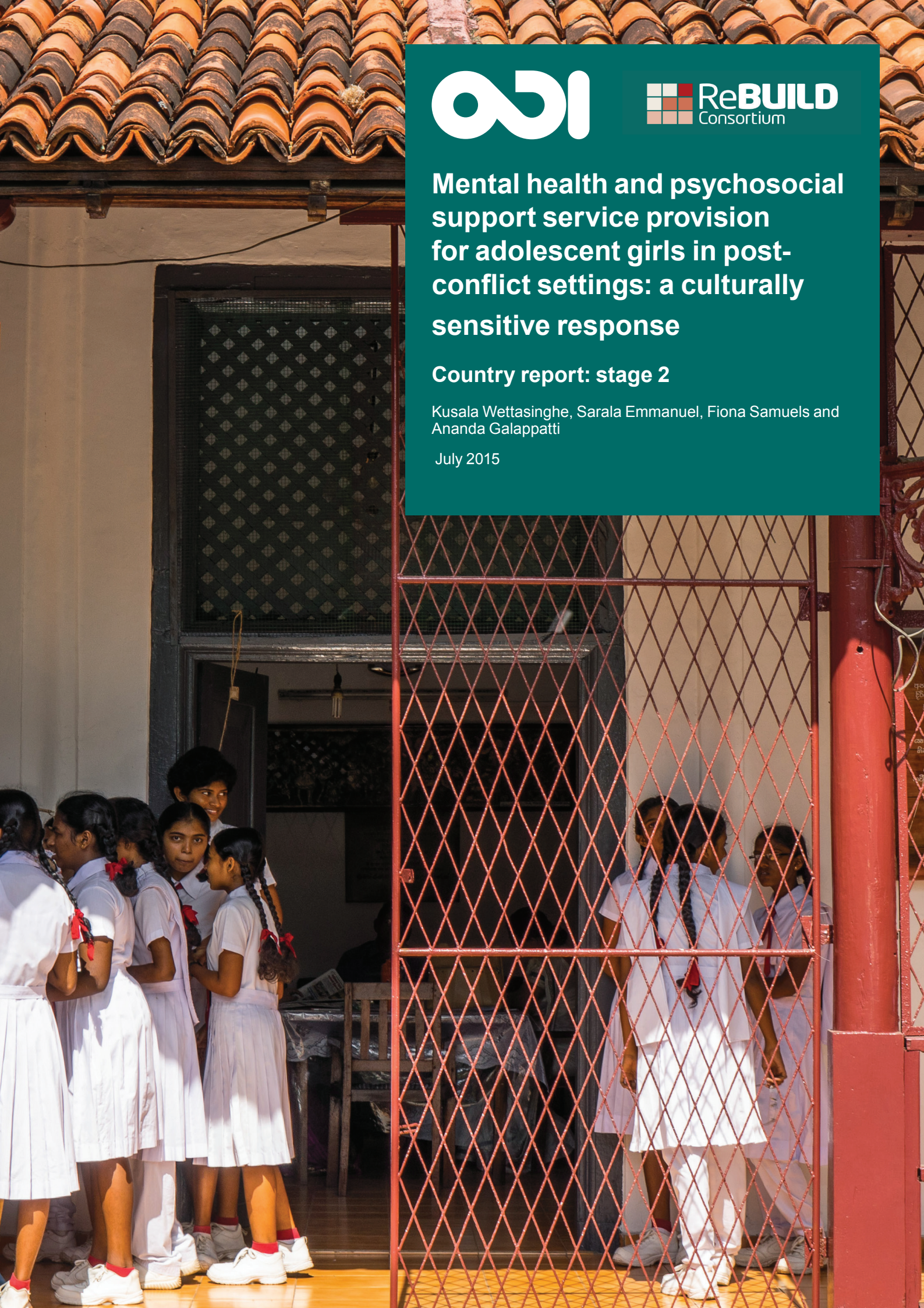
July 2015

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Abbreviations

CACM	Church of American Ceylon Mission
CGO	Career Guidance Officer
CRPO	Child Rights Promotion Officer
DPCC	Department of Probation and Child Care
DS	Divisional Secretariat
ESCO	Eastern Self Reliant Community Awakening Organization
ESDF	Eastern Social Development Foundation
ETU	Emergency Treatment Unit
FHW	Family Health Worker (also known as PHM – Public Health Midwife)
FPA	Family Planning Association
GBV	Gender-Based Violence
GCE A/L	General Certificate of Education, Advanced Level
GCE O/L	General Certificate of Education, Ordinary Level
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GS	Grama Sevaka (also known as Grama Niladari)
MHPSS	Mental health and psychosocial support
MHU	Mental Health Unit
MOH	Medical Officer of Health
NAITA	National Apprentice and Industrial Training Authority
NCPA	National Child Protection Authority
NGO	Non-governmental organisation
NVQ	National Vocational Qualification
PO	Probation Officer
POIC	Probation Officer in Charge

SRH	Sexual and Reproductive Health
SSO	Social Service Officer
VTA	Vocational Training Authority
WIN	Women in Need

Executive summary

The research reported on in this report is the second stage of a study conducted by the Overseas Development Institute (UK) and The Good Practice Group (Sri Lanka) with the support from the ReBUILD Consortium, a research partnership funded by the UK Department for International Development[1]. The study sought to assess if existing services and other responses to the mental health and psychosocial problems experienced by adolescent girls in Sri Lanka's post-conflict settings are sufficiently informed by an understanding of context, gender and socio-cultural norms. The first stage of the study focused on mapping adolescents' and adults' perceptions of wellbeing and the factors that have an impact on adolescent wellbeing in post-conflict communities, and understanding the nature of services available for adolescents at ground-level. The second stage of the research built on these findings and examined in greater depth the nature and quality of mental health and psychosocial support (MHPSS) services available. It also examined if and how these services responded to the mental health and psychosocial issues identified during the initial stage of the research.

The study assessed the quality of specific services selected as relevant to the mental health and psychosocial issues identified during Stage 1. Fieldwork for the second stage of research was carried out in Kadalkiramam (pseudonym) in Batticaloa District in the Eastern Province of Sri Lanka. The research tools used for Stage 2 included service mapping, facility mapping, key informant interviews (KIIs) with 11 service providers and two focus group discussions (FGDs). The total number of persons interviewed was 39. Attempts were made to interview adolescents and their families to document their experience of services, but the research team was unable to gain the necessary access to carry out these interviews (see report for details). Instead, the research team used data from Stage 1 of the research and drew on 20 in-depth interviews and 8 case studies to inform their analysis.

The key psychosocial and mental health challenges centre around poverty-related vulnerabilities, socio-cultural practices such as early marriage, the gendered experiences of girls around morality and the control of sexuality, and violence associated with sexual abuse and incest. In terms of coping with psychosocial and mental health challenges, adolescents seem to take responsibility for their own wellbeing by seeking positive experiences or avoiding negative behaviour. However, the level of care they receive from caregivers also appears to have a profound impact on their levels of wellbeing.

The study found that in Batticaloa district alone there are over 50 distinct services that have a direct impact on adolescents' protection and psychosocial wellbeing. These kinds of services can be divided into four broad categories: those provided by the state, by NGOs, by the private sector and by structured community voluntary services. The state is the main service provider of health, education and child protection related services, and also maintains authority over service delivery mechanisms through centralised policy formulation, monitoring and resource allocation. NGOs involvement in services is related to the participation of adolescents and promoting agency through children's clubs and training programmes for youths and children. While the state and NGOs are also prominent in providing economic assistance and vocational training, KIIs with service providers indicate that vocational training by both the state and NGOs is not utilised sufficiently by adolescents. The private sector also provides some services in health and education, but access is generally mediated by affordability and necessity. Structured community voluntary services on the other hand are usually linked to state and NGO services, where the memberships of volunteer groups comprise community leaders, family health workers and caregivers. Volunteers provide support to public health services, participate in school attendance committees and are involved with village child rights

monitoring committees, where they are known to deal with adolescent issues such as sexual relationships and sexual abuse.

State and non-state MHPSS service providers for adolescents are characterised by vertical (local to national) and horizontal (inter-sectoral) integration. The variable quality of collaboration is a cross-cutting issue that impacts on the integration of services in general. Where the state mechanisms for health, education and child protection sectors are vertically integrated, collaboration between different sectors was not strongly promoted. Links between education and vocational training or education and health also lack consistency and tend to reduce the effectiveness of collaboration. On the other hand, long-term collaboration between the state services and non-state service providers showed a positive correlation with the integration of services offered. However, the study found that overall integration was weak, lacked consistency in the coordination of services and was often ad-hoc and reactive – often emerging as a response to a crisis situation.

There is a gap between policy and practice in the MHPSS service providers' approach and delivery of services to adolescents in general. The state's health, education and child protection policies promote equal access across socio-economic strata. However, the approach to service delivery at ground level fails to distinguish the needs of adolescents from those of younger children. Services delivery is formulated based on a restrictive and normative understanding of childhood and family, and there little consideration of the diverse realities of adolescents' lives. This approach also tends to exclude adolescents living in disadvantaged circumstances, which has particular negative impacts on the lives of adolescent girls.

The service providers' attitudes to service delivery reflect the social norms and values of the study community. Especially in the case of adolescent girls, service provision is influenced by considerations of moral conduct, where girls are often penalised for disregarding moral codes. The gendered and moralistic attitudes of service providers tend to mediate the provision of services for adolescent girls, despite a policy environment where state and non-state services claim to promote equal access to services. This attitude is also reflected in adolescent girls themselves, who seem to internalise community norms and accept restrictions as normal. Service providers, in general, view issues pertaining to adolescent girls as in terms of the failure of adolescent girls and their families to abide by socially accepted norms. This often discourages adolescent girls from accessing services for fear of being reprimanded or shamed.

The impact of MHPSS services on adolescents' wellbeing and protection emphasises the irregularities in services available to adolescents. While the state sector and non-state sectors provides protection and access to essential services like health, education and vocational training, these services tend to be general and not particularly sensitive towards adolescents. These services also categorise adolescents as 'children' under the age of 18, failing to recognise the diverse identities and roles that adolescents from the study community occupy. While adolescents who do not fit this definition are not denied services outright, the service providers remain critical of these 'deviations'. This disconnect motivates adolescents to devise coping mechanisms that may entail, on the one hand, their rejection of services and, on the other, their adoption of 'deviant' identities to challenge norms.

The mapping of services demonstrates that the Batticaloa district has a wide range of MHPSS service mechanisms in place. However, many of these mechanisms do not deal specifically with adolescents and do not adequately address the complex issues that adolescents face in the post-war context. Service providers need to take measures to identify adolescents at risk, adopt a more empathetic approach to strengthen their sense of being supported, support adolescent girls in negotiating conflicting social priorities, acknowledge adolescents' diverse identities and how these contribute to self-worth, and provide safe spaces for them to discuss issues of concern openly. Service providers should also better address disruptive family relationships that affect adolescents and critically examine data that hides the realities of adolescents' lives. Furthermore, the current 'child'-focused approach that state and non-state policy and practice implement must also be challenged as it excludes adolescents. If service providers are to better address the needs of adolescents, then the approaches to service provision must be more open, flexible and innovative.

1 Introduction

The overall objective of this research study was to consider whether services addressing mental health and psychosocial problems among adolescent girls in post-conflict settings are sufficiently informed by understandings of context, gender and socio-cultural norms. The premise of the study was that services do not consider these factors adequately and may even exacerbate discriminatory social norms and practices. It is hoped that findings from this study will help inform programme and service delivery mechanisms as well as policy-makers on appropriate, sensitive approaches to dealing with psychosocial stresses and issues of mental health among adolescents in post-conflict situations.

The second stage of this study was carried out in Kadalkiramam[2] in Batticaloa District, Eastern Province of Sri Lanka, in February and March 2015[3]. Kadalkiramam was one of the two villages in which the first stage of the research was carried out, and was chosen for focused study because of its better prospects of access to service providers. Kadalkiramam is situated in the north of Batticaloa and is close to the main access road to the district. Traditionally a fishing village, Kadalkiramam is urban in location and the majority of its population of nearly 3,000 is Tamil[4].

Batticaloa is among the three lowest-ranked districts in the Human Development Index and the Gender Inequality Index (Sri Lanka Human Development Report, 2012). Income poverty increased from 10.7% in 2006/07 to 20.3% in 2009/10. According to the Poverty Head Count Index, Batticaloa district had the highest levels of poverty in the country and the worst Poverty Gap index score (5.1, compared to a national average of 1.7)[5]. Educational achievements for primary and secondary grades were lower in Batticaloa than the national average. General Certificate of Education (GCE) Advanced Level (A/L) achievement was 8.0%, compared to the national average of 12.3%. The country average for attainment of university degrees or higher was 2.7% versus 2.3% in Batticaloa (Population Atlas, Department of Census and Statistics, 2012). According to the National Human Development Report of 2014, only 55% of the survey respondents in Batticaloa had completed secondary education, passing their GCE Ordinary Level (O/L) examination.

Experiences of armed conflict are in the social narratives of the village and district. The village of Kadalkiramam has always been in a high security area with large military camps nearby. It has a history of child soldier recruitment by the Liberation Tigers of Tamil Eelam (and after 2004 the breakaway Tamil Makkal Viduthalai Pulikal). There has also been a history of children's rights organisations working in the area.

In the six years since active warfare ended in Sri Lanka, there has been a considerable effort on the part of the state to invest in public services such as health and education. In the interviews with service providers, it was clear that there has been a concerted effort to fill new cadre positions for child protection and teaching. The public health system and hospital-based health care is also functioning, although there are still some gaps in personnel (see below for detailed discussion).

Objectives

The overall aim of the second stage of this study was to build on the research conducted during the first stage and explore how sensitive mental health and psychosocial support (MHPSS) services were to adolescents'

2 Pseudonym used to safeguard the privacy of the children.
3 Fieldwork for Stage 2 of the research reported on here was carried out by Kusala Wettesinghe, Sarala Emmanuel, Sivaprashanthi Thambaiah, Thambipillai Sarojini and Indrani Rajendran, with logistical assistance from Neelakandan Darmaratnam and Mohammad Buhari of the Eastern Social Development Foundation This summary report was prepared with assistance from Zainab Ibrahim.
4 Divisional Secretariat data, accessed in 2014. Exact population figures not used for purpose of anonymisation.
5 This does not include several conflict-affected districts in the north of Sri Lanka.

needs, particularly those of girls, and how services need to be improved. It also aimed to identify if and how key mental health and psychosocial issues for adolescents identified during the first stage of research were being addressed by MHPSS services.

The guiding research questions used for Stage 2 of the study were as follows:

1. What formal approaches and responses are available for dealing with mental health and psychosocial stresses and what paradigms do the practitioners working in these services adopt?
   - To what extent are they informed by a gender perspective?
   - To what extent are they informed by socio-cultural specificities?
   - How does the supply of mental health/psycho-social services (and lack of prioritising these aspects) in post-conflict contexts affect the experiences of adolescents in dealing with psychosocial problems?

2. What informal coping strategies are adolescents and their communities adopting to deal with mental health and psychosocial problems?
   - Which are promising/adaptive?
   - Which are potentially negative/risky?

3. To what extent have service providers and practitioners kept abreast of changes in the circumstances of adolescents since the end of active conflict?
   - What sorts of capacity-building opportunities have they been offered, if any?
   - What are the key gaps in their training and approaches?

4. How could formal approaches for providing support or promoting wellbeing be strengthened and tailored to take into account the longer-term psychosocial needs of adolescent girls in post-conflict settings and the gaps that need to be bridged in current human resourcing?

2 Methodology

Stage 2 of the research project studied the quality of specific services, selected for their relevance to the mental health and psychosocial issues identified in Stage 1. This study did not cover all services available in the study location, although an overall mapping was done with service providers.

The tools used were service mapping, facility mapping, key informant interviews (KII), and focus group discussions (FGD). The number of people interviewed was 39.

The team conducted a one-day workshop with key service providers in the area to present the findings from Stage 1 of the research, carry out a service mapping and discuss challenges, gaps and possible recommendations for a presentation on national-level policy.

KIIs were conducted with: the Medical Officer (Psychiatry) at the Valaichenai Hospital; the Probation Officer (PO), Batticaloa Central Zonal Education Officer; Career Guidance Officers (CGOs) and trainers; a Disciplinary Committee member of the local school; the heads of two local NGOs that work with adolescent girls in the area; a manager of a girls' home; the manager of projects of the American Mission Church, who also worked with adolescents; and an Islamic religious leader.

Facility checklists were conducted with the Gender-Based Violence (GBV) Desk at the Valaichenai Hospital, the Zonal Education Officer, the local school, Mental Health Unit (MHU) of the Valaichenai Hospital and the Eastern Self Reliant Community Awakening Organization (ESCO), an NGO working with adolescents.

The two **FGDs** were with the nursing staff of the Valaichenai Hospital and the child rights related officers at the Divisional Secretariat office.

The **workshop** included a cross-section of service providers including the principal of the local school, guidance and counselling teacher, NGO staff, a PO, a Village Child Rights Monitoring Committee member, Women's Development Officers and the GBV Desk Officer of the Valaichenai hospital.

Table 1: Research tools

Tool	Planned	Done
Mapping table	1	1
Facility checklists	5	5
Workshop	1	1
KII	12	11
FGD Service Providers	0	2
IDI users	0	4 (completed in Stage 1)
IDI caregiver, family, friends	0	0

Limitations

Applying the facility mapping tool was challenging as it was very lengthy to implement and respondents were unwilling to spend the time it required. Organisations with a long history of work also found it difficult and burdensome to provide details on, for example, the training they had received over the years. Some information was clearly not available in a form that could be easily accessed or shared with the interviewers and in other cases respondents did not feel authorised to share information. The KIIs were also challenging as respondents were resistant to responding to some questions – again including time-consuming answers on what training they had received.

Although interviews were planned with adolescents and their families to document their experiences of services, we were unable to carry these out for several reasons. First, even though local state caseworkers were agreeable to informally arranging meetings with adolescent and their families, they were unable to do so officially due to strict guidelines about providing information to NGOs without higher level approval. Where the research team tried to arrange two interviews with adolescents through informal introductions by a government officer, the families of the adolescents were unwilling to speak with the research team as they did not want to draw attention to the case again.

There were significant challenges in accessing information about state services due to the prevailing political conditions locally and nationally. The government viewed NGOs and international organisations with considerable suspicion and actively discouraged cooperation and sharing information with such entities. At a local level, this translated into difficult and sometimes antagonistic dynamics between government and non-government entities. Even where there were good relations between government and non-government staff at a personal level, this climate clearly contributed to the reluctance of many local government providers to share information with entities outside the government. Strategies such as conducting data-gathering through a workshop (less individually risky) were adopted to try to overcome these factors.

The research team explored a number of different avenues for accessing state service providers as well as the adolescents who had experience with the services. Since appropriate access within the fieldwork timeframe proved extremely challenging, it was decided to draw on the rich information already gathered from 20 in-depth interviews and 8 case studies with adolescent girls and boys conducted during Stage 1 of the study to inform our analysis.

3 Key psycho-social and mental health challenges faced by adolescents

This section draws on interviews and FGDs conducted with adolescents in Stage 1 of the research project.

The psychosocial wellbeing of adolescent boys and girls in the studied communities were discussed in detail in the Stage 1 study report and organised into seven domains based on the Wellbeing in Developing Countries (WeD) framework developed by the WeD Research Group using the Psychosocial Assessment of Development and Humanitarian Interventions (PADHI)[6] wellbeing framework as its prototype. These domains are: (1) access to resources; (2) building social connections; (3) sustaining close relationships; (4) exercising participation/agency; (5) experiencing self-worth; (6) enjoying spiritual wellbeing; and (7) enhancing physical and mental wellness and security.

The study explored adolescents' perceptions of wellbeing within these seven domains. It then looked at their actual situations of wellbeing, drawing on their own experiences and those of their parents, grandparents, other community elders and key informants.

The markers of wellbeing that adolescents identified were related to supportive families and school environments, positive social interactions, personal behaviours that were seen as socially or culturally acceptable and therefore positive, economic stability, a sense of self-worth and confidence, having religious or spiritual experiences, and taking initiative for one's own self-development.

> *I want to study and become a judge ... My uncle and grandmother will support me ... My uncle wants me to do science. He told me to study to be a doctor. I told him if a doctor has a problem he has to come to the courts.*
>
> Source: Girl 15, Kadalkiramam

The markers of ill-being included disruptive family relationships, negative social interactions (keeping 'unsuitable/bad' company and poor social relationships), socially unacceptable/inappropriate conduct, unhealthy personal habits, being isolated, withdrawn, angry, apathetic or unhappy, having poor self-esteem, and economic difficulties.

> *I started volleyball at the age of 13 ... I have played volleyball, elle [traditional game], cricket and I was on the school team ... I can run well ... I got selected for the music competition too. After I attained age they [parents] did not allow me to come to the road, I was not allowed to go to church, I only went to school and I stayed at home. They did not allow me to go for tuition, they did not allow me to go anywhere.*
>
> Source: Girl 18, Kadalkiramam

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6 PADHI was set up in 2006 as a two-year programme under the Social Policy Analysis and Research Centre affiliated to the University of Colombo (PADHI, 2009).

The psychosocial issues highlighted by the adolescents, care givers and service providers were mainly related to the compounding vulnerabilities of poverty, socio-cultural practices such as early marriage, gendered experiences of girls around morality and control of sexuality as well as violence associated with sexual abuse and incest. Further, service providers and parents in Stage 1 and Stage 2 of the research pointed to early marriage as a problem, but adolescent boys and girls did not identify it as a marker of ill-being. These issues were discussed in depth in the Stage 1 report and are only mentioned in summary in this one. Based on the issues identified (see key areas below), the Stage 2 report focuses on services and how they respond to adolescent needs.

Key issues affecting adolescents' wellbeing were discussed in detail in Stage 1 of this study. In summary, the main issues identified by adolescents, care givers and service providers in Stage 1 were:

- Suicide, attempted suicide and self-harm
- Issues of family disintegration
- Protection and issues around early marriage and teenage pregnancies
- Incest
- Education and support for education
- A disconnect between adolescents' aspirations, youth culture and parent/community protection mechanisms.

Coping strategies

Adolescents coped with these issues by drawing on their own strengths or the support of a trusted adult, usually a caregiver or a supportive teacher in the school. An interesting point to note is that adolescents seemed to take responsibility for their own wellbeing, either through seeking out positive relationships or experiences or by actively avoiding negative behaviour. Adolescents who had the affectionate care and support of at least one parent or one or two extended family members or friends were, despite hardship, resilient and did not see themselves as inevitably linked to adversity. They also felt they could achieve a better future. Thus, children chose to move to other households where there was a caring adult, go to friends' houses to study where there was more support for studying, actively search for small jobs to do to be seen to be helpful in the community and to win support from community members, or participate in religious activities with friends, a socially acceptable way of engaging in public space. Adolescent girls also coped better when there were caring social workers who visited them regularly and showed an interest in their grades and educational material needs and with whom they could talk confidentially. Adolescents spoke about having at least one teacher who cared about their wellbeing and with whom they could talk to in confidence as being important in helping them to cope with their challenging home environment. They felt motivated to study when teachers believed in their capacities to achieve academic success and realise a better future. This has encouraged girls especially to strive hard to achieve their goals despite adversity.

Box 1: Caregiver qualities that win adolescents' trust

According to the boys and girls interviewed through IDIs and FGDs in Stage 1 of the research, almost all the adolescents have or remember having the care, consideration and support of at least one teacher in their school, often in the primary or lower secondary classes. What they appreciated the most about these teachers was the caring way in which they responded, the time they took to listen to the student's problems, which they did not discuss publicly with other teachers, and that they helped or advised in whatever way they could. The adolescents felt valued when these teachers inquired after their problems or their health if they were absent for a considerable time. If such teachers were transferred their absence was felt most keenly by adolescents who were distressed, marginalised or socially less active to the degree that they could not easily build another supportive link at school.

Where parental affection or consistent support from other adults was absent, and sometimes coupled with repeated ill treatment and humiliation by relatives, adolescents' self-esteem was affected. Despite aspirations

of a better future and of living with dignity, they oscillated between determination and lack of agency to achieve these goals.

Box 2: What strengthens adolescent girls' resilience and determination to pursue their education and aspire for a career

A combination of factors that include:

- Freedom to attend school – not pulling girls out of school to marry or to ensure their safety
- Having a school within an accessible distance
- Having access to basic school materials
- Having at least one member in the family or a caregiver who believes in the their capability to study well and achieve career goals
- Consistent support from at least one caregiver or family member
- At least a few caring and supportive teachers in the school who listen to their problems and offer encouragement
- Personal characteristics and outlook (often influenced in turn by the outlook of significant caregivers)

4 Overview of services that impact on adolescent girls' wellbeing

This section discusses the type of services available and how they have been operationalised. Section 4.1 provides and overview of the types of services significant in promoting adolescents' wellbeing and 4.2 highlights the level of integration and collaboration across different levels and in different sectors. Section 4.3 discusses the approaches to provision of these key services and its impact on adolescents' access to them.

4.1 Types of services

There are over 50 services in Batticaloa that directly impact on adolescents' protection and psychosocial wellbeing. These were mapped by the service providers who participated in the workshop conducted in the second phase of data collection and were verified by other service providers interviewed for the study. Table 3 presents an indicative outline of these services as relevant to adolescent girls. This is not an exhaustive list and is limited to data collected from a sample of representatives of the types of service provision. As can be seen in the table, four types of main service providers are identified: (1) the state, (2) NGOs, (3) private sector, and (4) structured community voluntary services. The last category provides examples of services provided through a collaboration between state and non-state sectors.

Table 2: Outline of main services relevant to adolescent girls' wellbeing and protection (as mentioned by interviewees)

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Health	State sector: Primary health services through Family Health Workers (FHWs). Mainly pre- and post-natal care of mother and child. Proactive in preventing teenage pregnancies	Medical Officer of Health (MOH) clinics – FHWs are attached to MOHs Valaichenai hospital – MHU, Maternity ward and Emergency Treatment Unit	Batticaloa Hospital – especially MHU and ETU highlighted in relation to adolescents	Ministry of Health – policy, planning and resource allocation Directorate of Mental Health

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Health		(ETU) were highlighted in relation to adolescents Counsellor at DS office		National Institute of Mental Health
	NGOs: Child Psychosocial and MH wellbeing promotion programmes – ESCO	Child Psychosocial and MH wellbeing promotion programmes – ESCO Counselling services by NGOs	Family Planning Association (FPA) outreach services	SRH hotline operated by FPA SRH related services through FPA
	Community: Traditional healers	-	-	-
	Private sector: Private dispensaries	Private medical centres and laboratories	Private hospital in Batticaloa	-
	Collaborations: MOH/NGO awareness programmes in schools & community.	GBV Desk at Valaichenai Hospital and supported by NGOs	GBV desk – Batticaloa Hospital, supported by NGOs	
	State sector:	Zonal education offices – support to schools		Ministry of Education – policy making and

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Education	Village/village cluster-based state schools School based counselling and career guidance awareness	These are placed under the purview of the Provincial Ministry of Education		generalised standards stipulation. Conduction of public examinations at grade 5 (scholarship exam and GCE O/L & A/L). National Institute of Education (NIE) – develops school curriculum, text books and organises teacher training.
	NGOs: NGO interventions operate through schools in collaboration with the state school education mechanism			
	Community: Free tuition classes, where these exist, are organised by community/religious institutions in the community or through school development societies) Some community leaders are members of school attendance committees			

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Education	**Private sector:** Fee levying tuition classes for school children by individuals	Fee levying tuition classes Fee levying schools e.g. Fee levying religious private school in Kattankudi	Fee levying tuition classes Fee levying schools (some of these are semi government schools partly supported by the state)	
	Collaborations: NGO support to train counsellor teachers/teachers of local schools – ESCO NGO Support to conduct awareness raising programmes on counselling/ career guidance	NGO support to conduct psychosocial training to counsellor teachers/teachers of state schools – GIZ	NIE-GIZ counsellor teacher training (though collaboration with GIZ)	
Protection	**State sector:** CRPO Community Women and Child Desk Taskforce (Social Service Officer (SSO), VRCMC led mechanism working on child protection)	POs and Zonal Department of Probation and Child Care (DPCC) offices Children's welfare homes	Probation Officer In Charge (POIC) and DPCC district office Snehadeepam – state safe house for children	Hotlines : • 1929 (NCPA) • Ministry of Women's Affairs hotline Department of Probation and Child Care (DPCC)

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Protection	PO working on reported cases of child abuse/risk of abuse and providing awareness raising PO and Child Rights Promotion Officer (CRPO) awareness programmes in schools	Legal Aid Commission Mediation board –for issues such as petty thefts Women and Child Desk at police stations	Human Rights Commission Police hotline 119 District Committee on Protection of Children	National Child Protection Authority (NCPA)
	NGOs: NGO Support to develop capacities of VCRMC members – ESCO former programme Child rights and protection related awareness by NGOs – ESCO, the Eastern Social Development Foundation (ESDF), Plan Sri Lanka, World Vision etc.	Support to develop capacities of VCRMC members – ESCO former programme Child rights and protection related awareness by NGOs – ESCO, Plan Sri Lanka, World Vision etc.	Koinoniya (NGO) safe house for women & children Women In Need (WIN) outreach services District based NGOs – Suriya and HHR (Home for Human Rights)	WIN hotline Safe houses, counselling, legal support by WIN
	Community: VCRMC – organised through the state (CRPOs) has	Mosque and Qazi courts and Madrasa	-	-

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
	membership of community leaders	(for Muslim community)		
	Collaborations: NGO support to conduct awareness raising programmes in schools	NGO support to conduct awareness raising programmes in schools Some NGOs conduct training programmes for POs/CRPOs	Some NGOs conduct training programmes for POs/CRPOs	-
Promoting participation and agency	**State sector:** POs facilitate registration of children's clubs[7]	POs facilitate registration of children's clubs	POs facilitate registration of children's clubs	Registration of all children's clubs under the DPCC (through district DPCC offices)
	NGOs: Children's and Youth clubs and resource centres, children's libraries etc supported by NGOs –E.g. ESCO, Plan Sri Lanka, World Vision Youth empowerment projects: ESCO's DEALS project	Children and Youth clubs operated by NGOs Training programmes on soft skills – through NGOs	District level committees linking community children's / youth clubs (ESCO)	

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7 All children's clubs are required to be registered under the DPCC.

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Promoting participation and agency	**Community:** Community leaders/ members voluntary support to children's clubs. This may also be facilitated through CBOs	-	-	-
	Private sector: Donations by local traders for events (sports meets, new year celebrations & religious programmes etc) organised through children's/youth clubs	-	-	-
	CollaborEations: POs / CRPOs engage with local children's[8] clubs (supported by NGOs) & monitors their activities CRPOs/POs conduct training programmes for children's clubs	CRPOs/POs conduct training programmes for children's clubs	POIC / POs participate in NGO facilitated planning/review meetings of NGO programmes to promote children's wellbeing, protection etc.	-
Economic & social service support[9]	**State sector:** Grama Sevaka (GS) and SSO facilitates	State vocational training – NVQ certificates through	Classes for NVQ higher levels are conducted at in the	VTA, NAITA

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8 Children's clubs membership includes children up to 18 years. Many of those in GCE A/L classes are 18 but are still considered as children as they are still in school.

9 Note that in this report vocational training is listed under economic services

	Community level (mainly focusing on the community of Kadalkiramam)	DS/Zonal level Valaichenai/ Oddamavadi / Kalkudah	District level Services located in Batticaloa town	National level (if mentioned by respondents)
Economic & social service support	allowance for disabled persons/ children Samurdhi – state poverty alleviation programme	the Vocational Training Authority (VTA) and the National Apprentice and Industrial Training Authority (NAITA)	main towns of the districts	Non-formal education unit of the Ministry of Education Samurdhi programme managed by the Samurdhi Authority at national level
	NGOs: NGO supported economic support to selected families e.g. by ESDF Programmes to support for migrant workers' families – ESCO	NGO supported Vocational training facility in Pudukuduirruppu & by the Church of American Ceylon Mission (CACM) etc.	Vocational training centre by Sarvodaya	
	Community: CBO self-help groups/micro credit for livelihood activities			

The state is the main service provider of health, education and child protection related services. It maintains overall authority and management of the main service delivery mechanisms through centralised policy formulation, overall monitoring and resource allocation. NGOs in these sectors work mostly through state mechanisms, collaborating and at times duplicating such services. Their services are mostly related to awareness raising, training, referrals and networking, facilitating health related services, facilitating legal support and support for infrastructure development. The involvement of NGOs is greater in services related to promoting the agency and participation of adolescents, especially through children's clubs and training programmes for children and youths. While the state poverty alleviation programme *Samurdhi* provides economic assistance to families below the poverty line, livelihood assistance programmes with limited outreach are operated by some NGOs. Both NGOs and the state are equally visible in the provision of vocational training. The state conducts tiered courses for the National Vocational Qualification (NVQ)

through fee-levying classes, and NGOs facilitate vocational training at DS or district based centres, with some providing incentives such as transport allowance and food to trainees. Nevertheless, the common understanding among service providers is that vocational training by both the state and NGOs is not used enough by adolescents and youth (see also discussion later in the report).

The private sector is mainly visible in the health and education sectors, though to varying degrees. The private sector operates services in parallel to the state and NGO mechanisms, operating private medical centres, for instance, or conducting private tuition classes for school children. These are secondary to the services provided by state and are used as optional supplements based on affordability and social acknowledgement of their necessity. For example, school children and parents tend to think that private tuition is necessary to score well in public school examinations. There are a few private fee-levying schools linked to religious institutions or run as international schools. A few district-based private sector enterprises are linked to vocational training institutes to provide employment for trained youth in hotels or as mechanics.

Structured community voluntary services are often linked to community-level state or NGO services. For example: health volunteers who assist Family Health Workers (FHWs); parents on School Attendance Committees linked to state schools of the area; Village Child Rights Monitoring Committees (VCRMCs) organised by the Child Rights Promotion Officers (CRPOs) with membership comprising community leaders and representatives of community based organisations; and Child Volunteer Committees linked to children's clubs.

According to the KIIs with CRPOs working in Muslim communities, *Quazi*[10] courts were mentioned as being active in dealing with some issues related to adolescents, such as sexual relationships and sexual abuse.[11]

Boxes 1-4 present a brief overview of the state mechanisms that provide education, child protection and health services in the study location.

Box 3: School Education

Eastern Province, consisting of Batticaloa, Ampara and Trincomalee, serves a total student population of 388,222 through 20,486 teachers in 1,064 schools. Of these, 432 are primary/junior secondary schools and 373 have classes up to GCE O/L. Facilities to study for A/L in science, arts or commerce are available in 77 schools (Ministry of Education, 2013).

Schools in Sri Lanka are categorised into five categories:

- Type 1 AB schools, which are further divided as national and provincial schools. Both these kinds of schools have classes up to GCE A/L in the study streams of arts, commerce and science and may or may not have a primary section. The national schools are managed by the Ministry of Education while the others are under the purview of the provincial education ministries.
- Type 1C schools have classes up to GCE A/L but have study streams only in arts and commerce.
- Type 2 schools have classes up to GCE O/L.
- Type 3 schools are mostly primary schools although some may have classes up to junior secondary (grade 8).

In the communities, a school is located in every village or village cluster. Although most schools at village level are primary schools or up to junior secondary, depending on the student population of the area, schools in village clusters may range from Type 3 to Type 1C. The school in the community studied was

10 Quazi courts are recognised bodies of the legal system and Quazis are appointed by the Judicial Services Commission. The main jurisdiction of the Quazi courts is marriage, divorce and maintenance related issues under the Muslim Personal Law of Sri Lanka. Even though it is not in the mandate of the Quazi courts, sometimes complaints related to sexual abuse are brought to them. The Sammelanam is another local body which comprises all the Mosque heads of the area. Families take concerns related to adolescents to the Sammelanam as well.
11 According to Muslim Personal Law in Sri Lanka, the age of marriage for a Muslim girl is 12, and marriage of a girl under 12 requires the permission of a Quazi. Sexual relationships and sexual abuse of adolescent girls sometimes lead to Quazi courts pressuring the girl to marry the boy/man.

Type 2. Students in schools with classes only up to primary or junior secondary have to travel to nearby towns to continue their upper secondary education.

The Kalkudah zonal education division serves about 30,000 students through 83 schools. Facilities such as electricity, water supply and adequate classrooms vary widely, with most of the larger schools in the towns having sufficient facilities. The school studied for this research served a student population of 428 (219 boys and 209 girls) at the time the study was conducted. The students are drawn from four nearby villages extending up to five kilometres. The school has 15 teachers and all have received training on basic mental health of children, psychological first aid, conflict resolution and inclusive teaching through a programme conducted by ESCO and BasicNeeds. In addition, two of the teachers are also trained through the NIE-GIZ programme on psychosocially sensitive teaching practices. The NIE-GIZ training covers psychosocial wellbeing, problem management, identity and power, communication skills, and peer supervision. The school premises have access to electricity but only the office and the activity room are supplied. Water is supplied through a tube well, which the counsellor teacher described as insufficient to serve the entire school. A separate room is allocated for psychosocial activities, including counselling but given the lack of space, this is located in a crowded area and does not provide the privacy required for counselling.

Box 4: Child protection services

Department of Probation and Child Care (DPCC)

Probation officers (POs) are attached to the DPCC and their main responsibilities are to investigate cases of child abuse or neglect of children, provide legal assistance, and support schools to resolve issues related to child protection. One of their main tasks is to conduct case conferences when incidents of child abuse or neglect are reported. This includes following the stipulated legal procedures to protect the affected children and file cases against the perpetrators of abuse. When an abused child is brought to the hospital or is reported to the police the POs are informed by these institutions. Similarly, if POs identify incidents of child abuse they are required to report this to the police within 24 hours. Usually incidents of abuse reported to the VCRMCs are referred to the PO or to the CRPO of the area. The GS or other ground-level officials or the community informs them of such incidents. Case conferences are coordinated by the PO who reports the case. As the case manager, they will organise a meeting with a Medical Officer (Psychiatry), a paediatrician, a CRPO, the police (if necessary), the school authorities (if the incidents happened in the school), and the parents or guardian of the affected child. The incident is investigated and measures to be taken to assist the child are decided at the case conferences. Affected children may be referred to a counsellor and placed in safe houses, through court procedures. POs follow up on these children and monitor their protection and wellbeing as well as facilitate their reintegration with their families when appropriate.

The PO of the study location, indicating the gravity of the issue of child abuse, said that he responds to 5-8 cases of sexual abuse of children every month. At the GBV desk of the hospital case conferences are held three times a month and 2-3 cases are discussed at each case conference. At the District Child Protection Unit case conferences are held twice a week.

POs also support adolescents who have faced experiences such as abuse or early pregnancy to resume their education or engage in vocational training and re-build their lives. They conduct follow-up visits with adolescents who have been treated at hospitals after suicide attempts to assess any continued risks as well as to facilitate support.

The POs mainly learn on the job but also receive training through diverse NGO and UN programmes: for instance, according to the KII with POs, in the recent past, they had received training through UNICEF and Save the Children Sri Lanka.

Child rights promotion mechanism

The National Child Protection Authority (NCPA) operates in parallel to the DPCC at national, district and divisional levels. At community level the CRPOs are mandated to conduct programmes to raise communities' awareness on child rights and protection. They also have the responsibility of organising VCRMCs in the communities to mobilise community initiatives to identify and refer cases of child abuse or neglect and promote children's wellbeing. Both the POs and CRPOs are active in promoting child rights and protection related awareness in schools.

In addition to the community-level mechanism, the NCPA operates a countrywide child helpline and investigates reported cases of abuse or harassment of children. Such investigations are conducted with the assistance of the police. Statistics at national level, reported to NCPA, highlight that 10,315 cases of child abuse were reported in 2014. Of these 508 were on rape and 522 were cases of sexual abuse. The most common cases reported were cases categorised as cruelty to children (2160 cases), and second most common was related to non-compliance with regulations of compulsory education (1470 cases). In the Batticaloa district, 71 cases of child abuse were reported to the NCPA between January and May 2015.

Box 5: Health services related to adolescent girls' issues

Primary health care at divisional and community level is managed by the MOH office, with the FHWs visiting communities to provide guidance on primary health care, provide prenatal and antenatal care, coordinate vaccination programmes at ground level and conduct programmes to raise awareness on nutrition. FHWs reach out to married adolescent girls to raise their awareness on avoiding teenage pregnancy and to link them to local MOH offices for contraceptive services, if necessary.

A FGD with the nursing staff and a KII with the Medical Officer (Psychiatry) of the hospital in Valaichenai highlighted that the ETU, maternity ward and the MHU are most important in providing health related services to adolescent girls. Adolescent girls with symptoms indicating pregnancy or post-abortion complications are referred to the maternity ward. If adolescent girls report signs of pregnancy the hospital conducts compulsory urine tests to determine pregnancy. These are carried out with or without the permission of the teenager and the parents/guardian who bring her to the hospital (see also discussion later in the report). Adolescent girls with complications after illegal abortions are also referred to the maternity ward. In both these situations if the adolescent is under age, the POs are informed by the hospital authorities. If sexual abuse is suspected the girls may also be referred to the GBV desk and the police desk of the hospitals. The affected girls are kept in the maternity ward until their situation is stabilised and in the case of pregnancy they are asked to visit the maternity clinic at the hospital. In 2014, there were 15 cases of adolescent pregnancies reported to the GBV Desk at the hospital.

The ETU services for adolescents who have attempted suicide

The ETU is the main unit that deals with adolescents who have attempted suicide. If suicide is attempted through ingesting poisonous substances or overdoes of medicine, the adolescent is referred to the medical ward after being treated at the ETU to address urgent medical issues. Depending on their condition and the nature of injury, patients are sent to the intensive care unit, the ward to treat burns, or to the MHU if psychiatric care is identified as the primary need. They may also be treated by the Medical Officer (Psychiatry) while in the other wards. If the patient is under 18 years of age, suicide attempts are reported to the PO, the police desk at the hospital and, if relevant, the GBV desk. Counselling services are facilitated through the MHU or the POs. POs follow up on the affected children after they are discharged from the hospital.

Box 6: Mental health services through the MHU

MHUs operate at both Valaichenai and Batticaloa hospitals. Valaichenai hospital is currently served by a Medical Officer (Psychiatry), medical officer for mental health, one nurse, a matron, GBV desk officer (Social Welfare Officer), two miscellaneous staff and two student psychosocial workers. Although the post

of the counsellor was vacant at the time of the study, two graduates from the Eastern University were working part-time as counsellors. The hospital serves around 30,000 people in the DS divisions of Vaharai, Valaichenai, Kiran and Oddamdavadi. Most of the patients are from Oddamavadi and Vaharai. The latter is about 75 kilometres from the hospital, or over two hours by bus. Sometimes patients are referred from Welikanda in Polonnaruwa and in such instances patients have to travel for over three hours. In a typical month about 100 patients seek treatment from the MHU and their age ranges from 12 to around 50. Among the patients are those who have attempted suicide, those who require counselling services, and those with mental illnesses that require psychiatric treatment. In Stage 1 of this study we documented that in 2013 there were three suicides and 14 attempted suicides reported to the Valaichenai hospital alone. Of the attempted suicides, six were by adult women and three by adolescent girls. The completed suicides were all by adult women. In 2014, there were 15 suicide attempts reported to the Valaichenai hospital between January and June alone: 12 women, two adolescent girls and one boy under 12 years old. There were also two completed suicides reported in 2014, both by women.

A range of therapies are used at the MHU and these include psychiatric care, counselling, aquatic therapy, and rehabilitation for patients who have suffered strokes. The MHU works closely with the GBV desk and also conducts training programmes on mental illnesses and mental wellbeing for state and non-state organisations. The Valaichenai hospital does not have specific services for adolescents.

At the MHU at the Batticaloa hospital, a clinic for adolescents is conducted on Friday afternoons and a clinic for children on Friday mornings. The clinics use methods such as art therapy are to engage with the children. According to the Psychiatrist of the Batticaloa hospital, most of the issues affecting adolescents' mental health problems stem from social issues and only a small percentage, 3-5%, are related to mental illnesses.

4.2 Integration of services

This section explores vertical service integration (i.e. integration of services from community level through district level to the national level), horizontal service integration (i.e. integration across different sectors and agencies operating at the same administrative level) and how each contributes to the quality of service provision. Vertical integration was visible mostly in the state sector. Horizontal linkages were less visible and often led to gaps in service provision.

Vertically integrated mechanisms of the state sector. As illustrated in Table 3 and in Boxes 1-4, the state mechanisms in the health, school education and child protection sectors are characterised by connectivity and integration across the vertical tiers: from community-based services to DS division, district and national level mechanisms. The prime target group of these services are children (under 18s) or the general public in relation to health services. However, children's and adolescent girls' protection and medical requirements are given particular consideration in health and child protection services.

In child protection related services, some confusion arises from the existence of two parallel service arms: POs dealing with abuse, neglect and legal aspects related to child protection incidences are attached to the district DPCC, operating under the provincial DPCC. Parallel to this, the CRPOs and the newly appointed National Child Protection Officers, who raise awareness on child rights and protection issues and investigate reported incidents of child abuse and exploitation, are under the national DPCC and National Child Protection Authority respectively within the Ministry of Child Development. Collaboration and any integration of work at ground level between these two service arms are determined by positive attitudes towards cooperation at the level of individual officers. Collaboration is not promoted formally through institutional mechanisms as these two systems work separately at district and national levels. According to national level service providers, despite the common focus, there is also distance between the DPCC and NCPA, which has its roots in the creation of the NCPA as an entity directly under the Executive President's office rather than the ministry responsible for the DPCC. Although both structures are now under the same ministerial management, historical tensions and distance prevail.

Horizontal integration. The value of inter-sectoral and inter-agency integration of services at the community level is recognised in state and district level policy and planning. At national and district level, policy formulation and planning efforts are made to link schools with health and protection related services. Schools provide easy access to children so awareness raising programmes on health and child protection are often conducted through the schools. For instance, school assessment criteria includes facilities to promote nutrition and health of children and schools are required to conduct at least one health screening programme for students with the support of the local MOH offices and the hospital. Similarly oral health inspection and awareness programmes have to be conducted in the schools.

Although these measures are specified in policy and by circulars issued to schools, there are significant lapses in operationalising these at ground level meaning that collaborative programmes tend to lack consistency, which reduces the effectiveness of the collaboration. Some examples of such gaps are discussed in Box 5.

Box 7: Issues of collaboration

Under the Ministry of Child Development[12], POs and CRPOs plan to conduct a specified number of awareness-raising programmes in schools annually and work closely with schools to enhance child protection. However, KIIs and FGDs with service providers highlighted that the priority given to such collaboration is generally low. While school authorities accommodate awareness programmes by CRPOs/POs, incidents of child abuse, especially sexual abuse, occurring in school are often not reported to child protection mechanisms. CRPOs and POs claim that school authorities try to resolve these issues within schools to avoid reputational damage. Such concealment reduces POs/CRPOs' ability to be alert to child protection risks and to ensure support the affected children. School authorities in turn raised concerns about the failure of POs/CRPOs to inform schools when case conferences are conducted about child abuse occurring outside school. They point out that given the amount of time children spend in schools, teachers are able to provide insight into children's behaviours and issues that can support such case conferences, but POs generally consult schools only if school personnel are alleged to be perpetrators or the abuse has happened within the school premises. Such compartmentalised service provision presents challenges in responding to the complex nature of problems experienced by adolescents living in adverse conditions.

Failures to integrate into the education system services that prepare adolescents for work life are seen to weaken adolescents' access to vocational training. Stage 1 of the study identified that adolescents do not make good use of vocational training facilities after they leave school. KIIs with CGOs highlighted the weak integration between vocational training and career guidance provided through schools and the low priority schools give to career guidance in upper secondary classes. Vocational training for youth is facilitated through the Ministry of Skills Development and Vocational Training while career guidance in schools is conducted under the Ministry of Education. As such, the use of vocational training opportunities by school leavers has inter-sectoral implications.

According to CGOs, the low priority given to career guidance in schools hinders their capacity to raise students' awareness on the career and vocational training choices available to them. The Zonal Education Offices have recently (2011) appointed CGOs who are expected to visit schools regularly and help students prepare for GCE O/L and A/L, to select optional subjects based on their aptitudes and to raise their awareness on career and vocational training opportunities. However, CGOs say that the space to engage with school students is severely limited to about three hours in each school, which is insufficient for meaningful career guidance. The main reasons given for this limitation are: students have little time to participate in other activities due to the heavy subject content of the GCE O/L and A/L syllabuses; school authorities de-prioritise vocational training and career guidance; CGOs have a heavy workload, visiting around 80 schools annually. The CGOs' role is sometimes confused with that of counsellors, in effect requiring them to work as both. This further reduces the time they have to discuss career options with students who have are not planning or likely to pursue tertiary education. Realistically, then, despite the availability of CGO services, students who do not enter university or other higher education streams are not sufficiently aware of or are not motivated to select vocational training options that meet their interests and aptitudes. The absence of a strong link between

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12 The Ministry of Child Development, during certain periods, was affiliated to the Ministry of Women's Affairs and was known as the Ministry of Women's Affairs and Child Development. Currently it functions separately as the Ministry of Child Development.

school education and vocational training results in large numbers of adolescents who drop out or leave school after A/Ls drifting aimlessly or stagnating in unskilled/semi-skilled work, or engaging in unviable and at times risky income earning options.

Horizontal linkages among service providers. Service integration between the state and the NGOs and bilateral agencies varies widely. More generally, the state oversees NGO interventions and NGOs have to seek approval for their programmes at district level. There are also specific regulations pertaining to children's programmes. For example, written approval from the Zonal Education office is required for all NGO interventions in schools; all children's clubs in communities have to be registered under the DPCC; and POs of the area are expected to attend annual general meetings and monitor the operations of the children's clubs.

Some NGO and bilateral agency-state programmes are of relatively long-term duration. The training of counsellor teachers by GIZ, for instance, demonstrates consistent collaboration and long-term financial and technical support. Successful interventions such as the GBV desk of the Batticaloa and Valaichenai hospitals (see Box 6) also display sustained state-NGO collaboration through continued support by a succession of NGOs: GBV desks have been financially supported by Care Sri Lanka, WIN, Neelan Thiruchelvam Trust through ESDF and New Arrow (local NGOs).

Box 8: GBV desk at the hospital

The GBV desk is a specialised centre for providing psychosocial support to survivors of GBV and is located at the hospitals in Valaichenai and Batticaloa. According to the KII with the GBV desk officer at the Valaichenai hospital, the services they provide range from meeting with families of affected persons and coordinating case conferences to providing counselling and making referrals for medical and legal support. The GBV desk works closely with the Medical Officer (Psychiatry), the MHU and the paediatric ward of the hospital.

Apart from the hospital based services, the GBV desk officer also conducts basic training on counselling to school teachers; raises awareness on prevention of GBV and avoidance of teenage pregnancies in schools and in communities through different NGOs; and makes home visits to follow up on service recipients, where necessary. The GBV desk at Valaichenai hospital typically deals with about 25-30 cases a month and links with about 1,500 people per year, comprising affected persons and their families or other significant people in the affected patients' lives.

Currently the centre is served by one Social Welfare Officer who is generally known in the hospital as the GBV desk officer. She has received counselling training through the Institute for Human Relations, Counselling and Psychotherapy through the Christian Counselling Centre, Vellur, India and GBV and psychosocial support training through short-term NGO training sessions. She feels that the service is particularly important to adolescent girls who come to the hospital because they do not often have a trusted person with whom they can discuss their problems. The GBV desk is managed by the Medical Superintendent of the hospital and reports monthly to the Regional Director of Health Services and quarterly to the Ministry of Health, which validates it as a state health sector service although it is supported financially and technically by NGOs. The GBV desk works closely with NGOs to access support for GBV survivors as well as for technical expertise on gender-related analysis of cases.

Most NGO-state collaboration, however, is of short duration. Frequent and effective collaboration between state and NGO agencies is visible mainly in the sharing of resource personnel across programmes: non-state resource persons are active in promoting awareness on child protection and children's agency, while state employees participate as resource persons or medical professionals in NGO programmes on health and wellbeing. For instance ESCO's project on promotion of child mental wellbeing, implemented in collaboration with BasicNeeds, has intermittently conducted medical screening camps for children of their project locations. The medical screening is done by MOHs where available, and the Medical Officer (Psychiatry) and Medical Officers of Mental Health also participate.

Collaborations or inter-sectoral linkages among NGOs working in different sectors such as livelihood support and child protection seem to be relatively weak. Most organisations work independently at ground level, despite networking at district and national levels. This situation is exacerbated by donor requirements for visibility and clear ownership of the projects they fund. For instance, they request original attendee lists for programmes, which can hinder efforts by NGOs to organise events collaboratively as each strives to have activities counted as part of their own programme. Collaboration requires resources and ownership to be shared, but if donors require resources and materials to be labelled as belonging to projects funded by them, it challenges the willingness to share ownership.

The collaborative linkages that do exist are related to child protection, legal services, safe house accommodation, providing limited economic support to families in need and sharing resource persons for training programmes. Such support is often ad hoc or reactive, responding to situations after a crisis or incident. The lack of consistent, proactive and holistic measures to prevent incidents of self-harm, abuse and neglect among adolescents, particularly girls, was highlighted in KIIs with several service providers. Weak integration is evident in the absence of collaborative inter-sectoral NGO planning to realise common long-term goals to address recurrent issues faced by adolescents. A service provider participating in the workshop noted that while there are 'many services in the Batticaloa district, there are also many problems that children [continue to] face', which highlights the lack of service coordination for meeting the diverse psychosocial needs of children, including adolescent girls.

4.3 Approach to service delivery

This section discusses approaches to the delivery of services significant to adolescents' wellbeing and considers how these approaches impact on adolescents' ability to access these services.

State health, education and child protection services are free of charge, indicating an approach that promotes equality of access across socio-economic groups. The principles of equality are extended to cover non-discrimination of girls and boys in education, protection or health services. This follows the universal principles of gender equality and the right to be treated equally that is guaranteed by the constitution of Sri Lanka.

The approach, in general, indicates a tendency to consider adolescents as children and formulate services based on the normative, even idealistic understanding of childhood and the family. This is evident in the lack of consideration of the diverse realities of adolescents' lives: for instance, as illustrated in Stage 1 of this research, IDIs with adolescents revealed that the composition of families varies and adolescents may live with grandparents or even non-relatives whom they consider as their family. Similarly, some adolescents may have to bear responsibilities to earn or care for their families, including sick or alcohol-dependent parents, which will influence their life choices. When these diverse realities are not considered or are seen through the lens of 'failure' (such as dropping out of school), it reduces the capacity of service providers to reach out to these adolescents living in disadvantaged circumstances, to cater to their needs, or/and to protect them from harmful consequences of their choices.

The specific approaches in education, child protection, health, vocational training and children's clubs services that promote adolescents' social interaction are discussed below:

School education – Promoting equality in access and prioritising academic achievements

Free education, including provision of free textbooks to all children and material for a set of school uniforms annually for all children, has facilitated equality in access to education. Gender equality has been a principle of school education from as far back as 1947 when free education for all children in Sri Lanka was adopted as government policy. In 1998 school education for children between the ages of 5 and 14 was made compulsory, which provided further support for equality of access to education across diverse socio economic groups. However, policies, mandatory regulations and welfare measures do not address all issues of inequity. For instance, students in schools that do not have GCE O/L or A/L classes have to travel to other towns or districts to continue their education. Remote locations and unreliable transport services often hinder girls' schooling. Having to transfer from a village school to one in the town, according to KIIs with education authorities, results in some girls and boys dropping out of schools. In low-income families this decision may

be influenced by the costs of better clothing to meet the standards of schools in towns, or transport costs, which affects both boys and girls. While some families may resort to dropping girls out of schools, others make efforts to support girls in pursuing their education, as illustrated in the IDIs and FGDs of Stage 1 of this research.

The Ministry of Education adopts a holistic approach to assessing schools using a wide range of criteria that aim to promote children's development and academic achievement as well as effective school management. Assessment criteria are categorised under the themes of educational performance, teaching and learning assessment, promoting engagement in aesthetic activities, participation in co-curricular activities, student wellbeing, leadership and management of the school, and engagement with the community.

KIIs with educational authorities and IDIs with adolescents conducted in Stage 1, however, indicate gaps between policy and practice. Respondents highlighted that an overriding emphasis is given to high academic achievement, especially gaining the best results at public school examinations. This undermines the need to support low performers and children faced with adversity such as family disintegration, parental migration (especially of mothers), lack of care, economic issues, and the need to work or care for younger siblings. As Stage 1 of this study illustrated, students struggling with these issues are unable to pay sufficient attention to their school work, and frequent absenteeism affects their progress in school work, resulting in them lagging behind in their studies.

IDIs with adolescents in Stage 1 noted that while some teachers are sensitive to the challenges of adolescents in disadvantageous situations and work closely with them, many tend to focus on the students who score high marks at examinations. The Medical Officer (Psychiatry) of the MHU stated that students who are 'weak' in schoolwork need extra coaching and those who continue to achieve low marks at examinations need space to develop and be recognised for their creative skills or other talents so they do not feel marginalised and neglected. He identified the lack of this support as a key reason that drove children to drop out of schools.

Key indicators used to assess success of the education system are the enrolment of children in grade one and their retention in school to complete the 13 years of schooling up to GCE A/L. If a child is continuously absent from school for 41 days without a valid reason of which the school is informed (e.g. a serious illness), they are considered to have dropped out of school. School dropout rates are monitored at zonal, district and national levels and schools take several measures to minimise dropouts. For instance, School Attendance Committees are organised to follow up on children who are absent for long periods and NGOs are engaged, intermittently, to provide school kits as an incentive to return to school[13]. Some schools also engage the Civil Defence Force and local police to 'scare' children into attending school. The negative impact of this approach on children's emotional wellbeing is evident: it clearly fails to address the deeper issues that children face or issues in the school system.

Health – preventative and post-incident care

Approaches to health services that are significant to adolescent girls' wellbeing are discussed in this section. The KIIs and FGDs conducted with health service staff highlight a greater emphasis on post-incident care.

FGDs with health staff on health services for adolescents mainly focused on issues of mental health, suicide, sexual and reproductive health and teenage pregnancies. These discussions highlighted that preventative services to address issues affecting adolescent girls mostly focused on awareness raising, with the exception of FHW and MOH office efforts to reduce teenage pregnancies. As discussed in Stage 1 of this research, FHWs attempt to build awareness among married teenage girls and their spouses' awareness of the negative health implications of teenage pregnancy and promote the use of appropriate contraceptives, linking the girls to local MOH clinics.

KIIs and a FGD with the nursing staff of the Valaichenai hospital indicated that the hospital is well equipped with trained staff and facilities (refer to Boxes 3 and 4 for details on the ETU and MHU) to provide emergency medical care and mental health services to adolescents brought to hospital after deliberate self-harm or

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13 Depending on the needs of students in particular schools and fund availability of the NGOs providing school kits, what is included in a kit will differ. Often it is school material (exercise books, school bags, pens, pencils etc.) while some kits may also include material for school uniforms and shoes.

violence. While the service mechanisms are not particularly designed to deal with adolescents, the experienced nursing staff, even though without formal training on counselling, are able to handle the emergency situation and provide emotional support to the affected adolescents. As nursing staff noted in the FGD, integrated care in such situations includes coordination among several divisions of the hospital, such as the ETU, general medical wards, maternity ward, burn care and, if necessary the MHU and the GBV and women and police desks. It is a mandatory requirement that POs are informed if patients are under 18.

Mental health professionals stress that although medical care and mental health services are provided for adolescents, the interventions should be social rather than clinical for girls and boys who are treated at the MHU. While medical care is provided to deal with the immediate health issues, the Psychiatrist of the Batticaloa hospital and the Medical Officer (Psychiatry) of the MHU in Valaichenai hospital stressed the need to address the social issues that are the root causes of self harm especially. The MHU employs a range of therapies, from counselling to psychiatric care (refer to Box 4 for details), but if the patients demonstrate continued risk of self-harm or harm to others, they are transferred to the main hospital in the Batticaloa town which has security mechanisms such as separate rooms and staff to monitor such patients.

Post-hospitalisation care includes both medical and social support. Continued medical care if necessary is provided through the MHU and relevant clinics of the hospital. Support to deal with family and social issues is facilitated by the GBV desk, if relevant, and the PO in the case of a child (under 18).

Care for adolescents surviving suicide attempts was well organised, although most of the health staff and other service providers spoken to, including educators, felt that suicide was not a key issue. They described the frequency of suicide attempts by adolescents as relatively low – according to KIIs with hospital staff, within the three months prior to this study, six adolescents (five girls and one boy) were admitted after suicide attempts – although it is not clear to the research team why this is considered low[14].

The lack of recognition of suicide as a crucial issue affecting adolescent girls in the study area reflects a failure to recognise the adversities and stresses of adolescents' lives that push some of them to attempt suicide. For adolescent girls, experiences such as early marriage, teenage pregnancy, economic hardship or being abandoned by their spouse contribute to an increased risk of suicide[15]. A lack of recognition of suicide as a priority issue in turn leads to a lack of acknowledgment of the need for psychosocial interventions and other mechanisms that provide emotional support to reduce the stress caused by these precipitating or contributory factors. One service provider, participating in the workshop, captured this issue when she said that there is less focus on prevention and that more emphasis is given to post-crisis care and support. This illustrates a need to acknowledge adolescents' suicide attempts as the tip of the iceberg of problems and stresses that erode adolescents' wellbeing.

Unlike suicide, teenage pregnancy is acknowledged by health service providers as a prevalent health and social issue affecting adolescent girls. Measures taken to deal with this include awareness-raising programmes in schools and in the community and training for adolescents and FHWs promoting the use of contraceptives to married teenagers. However, providing FHW services in the community and medical care at hospitals to pregnant unmarried teenage girls entails a different set of dynamics. While the hospital staff treat teenage pregnancies as a health risk that needs medical intervention and monitoring, families struggle with issues of social stigma and the need to conceal the pregnancy from relatives and neighbours. Families often conceal a teenage pregnancy as long as possible from neighbours and have the teenager admitted to a hospital in a distant location. (This is also discussed in Box 3 and later in the report.)

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14 Sri Lanka has very high suicide rates: Newsfirst (2014) 'New WHO reports ranks Sri Lanka fourth on suicide rates', 4 September (http://newsfirst.lk/english/2014/09/ranks-sri-lanka-4th-among-172-countries-suicide-rates/52199).

15 These experiences of adolescent girls were discussed at length in Stage 1 of this research. The legal age for marriage is 18. Girls who start co-habiting, which is customarily regarded by the community as marriage, may face abandonment after a few years. They have to struggle to survive, often bringing up one or two children. Their ability to engage in a viable livelihood is limited as they have not completed schooling and therefore have to work as unskilled/semi-skilled workers. Although they may be supported by their families with shelter and food, the parental families are also often poor and have difficulty in meeting the additional economic burden of caring for the adolescent mother and her child/children.

Protection – Providing awareness and legal support

Approaches to the protection of children, including adolescents, focus on promoting awareness on child rights, organising communities to support child rights and providing legal assistance in incidences of child abuse and neglect.

Recognition of child protection issues as well as a policy framework that recognises child rights has created a space to raise awareness on these issues. Additionally, POs, CRPOs and different NGOs have created the space to address child protection issues at the community and district level. Although statistical data was not available, some service providers who interacted closely with children noted an increase in children taking the initiative to report abuse and reach out to the probation department or the police by calling 119 when in distress. School authorities reported an increased interest by POs in conducting such programmes in schools and attributed it to programmes run by NGOs to raise awareness among service providers.

National-level MHPSS service providers and researchers raised two main concerns in relation to support for children. First, legal mechanisms/procedures to provide abused children with redress expose them to repeated recollection of incidents, causing further distress. Second, well-intentioned measures to keep affected children in safe-houses translates in practice to prolonged custodial detention away from their homes and family caused by long legal delays in obtaining redress, while perpetrators live freely. National-level policy discussions and lobbying is underway to repeal the current Children and Young Persons' Ordinance to provide affected children with positive and psychosocially sensitive support during legal procedures

Children's clubs – Promoting adolescents' agency and participation

Run largely by NGOs, the main approach to promoting children's participation and agency is through children's clubs, which facilitate awareness raising, training, educational support programmes and opportunities to explore their talents and to interact socially. Organising community activities such as religious and new year celebrations or sports and cultural events gives the members opportunities to develop their leadership skills and creative talents.

A common practice of NGOs working with children is to start their own children's club in the communities they work in. This has resulted in sometimes two or three clubs operating in one Grama Niladari division. The number of children's clubs or the number of children attending them is difficult to estimate. Since 2014 all children's clubs have to be registered with the DPCC, a procedure which takes time as registration requires the approval of the national DPCC. More recently the DPCC has also stipulated that only one children's club should function in one Grama Niladari division; though divisions that cover a large geographical area are able to accommodate two clubs.

Children's participation in club activities[16], according to KIIs with NGOs, is affected by children attending private tuition classes after school or during the weekend as well as some parents' disinclination to send their children to these clubs. As such, according to KIIs with NGO staff, only a relatively small percentage of children in the community are members. The clubs are open to both girls and boys, but in some areas where mixing of sexes is seen as a risk to girls' protection and respectability, families discourage girls from participating. NGOs such as ESCO, ESDF and the mission CACM have been responsive, meeting families to obtain permission for girls' participation and operating within the cultural norms of the area. As NGOs are keen to operate the children's clubs within the parameters of cultural appropriateness, there is less inclination to encourage school dropouts and working adolescents to become members of children's clubs, while married teenage girls generally do not participate. Service providers reported that the DS of Valaichenai has recently asked NGOs to open children's clubs to school dropouts so that they also have access to training and awareness-raising opportunities that other children access through schools and children's clubs. FGDs conducted with adolescents in Stage 1 of the study underlined the importance adolescents place on positive

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16 The Children's and Young Persons Ordinance, established in 1948 and subsequently revised, states its purpose as to 'Make provisions for the establishment of juvenile courts, for the supervision of juvenile offenders and for the protection of children and young persons and for other connected purposes.'

social interaction as a contributor to their wellbeing. Social restrictions that prevent school dropouts and working children from participating in children's clubs reduce their opportunities to benefit from opportunities to develop life skills.

Vocational training

This section explores approaches to vocational training and especially the gender dimensions that have an impact on girls' access to productive vocational training.

Box 9: State vocational training and apprenticeship facilities

The Vocational Training Authority (VTA) was established in 1995 to make vocational training more accessible to the rural youth and socio-economically disadvantaged communities. Originally placed under the Ministry of Labour, it now functions under the Ministry of Youth Affairs and Skills Development. The VTA's training facilities are spread across the country through 224 rural vocational training centres, 22 district centres and 7 national centres (VTA statistics, 2013). These centres trained a total of 25,799 youths in 83 trades in 2013. On completion of the period of training, trainees are directed for employment. They also are able to access a small grant through the VTA if they wish to start a small business.

Additionally, the National Apprenticeship and Industrial Training Authority (NAITA) places trained and semi-skilled youths to gain on-the-job training and practical experience working with the industries and enterprises registered with it

State vocational training mechanisms cater to adolescents and youths who seek out their services. Some NGOs operating vocational training services engage with families to recruit young people, especially girls, for longer-term training. The vocational training services offered through both state and non-state mechanisms show clear gender divisions in their overall use and in course selection. According to a KII with CACM, the ratio of girls to boys attending vocational training classes is generally around 1:3. In terms of courses, boys opt for training in motor mechanics, the hotel trade, refrigerator repairs, electronics and computer hardware. Girls' preferences include computer applications and beauty culture. Measures to overcome these gender differences did not emerge in the respondents' feedback.

CGOs have noted that adolescents, both girls and boys, opt mainly for short courses, wishing to find employment after completing Levels 2 or 3 of the NVQ, which limits their options to semi-skilled, low-wage jobs. The NVQ offers higher qualifications up to an Advanced Level Diploma at Level 5, assuring them of more viable employment. NGOs such as CACM have tried to engage with families to encourage adolescents to pursue long-term courses. A CGO respondent identified adolescents' and youths' preferences for short courses as a key issue that resulted in them not fully benefiting from the training opportunities available.

5 Influence of social norms and service provider attitudes' on service delivery

The attitudes of service providers were strongly impacted by the social norms and value systems prevalent in the community. Services to adolescents, especially girls, were influenced by considerations of moral conduct. Box 7 reviews the findings of Stage 1 relating to the engagement of communities, families and adolescents with the norms of moral conduct expected of children and youths.

Box 10: Adolescents, protection and expectations of moral conduct

One of the notable findings of Stage 1 of our study was that the primary concerns of communities and service providers responding to adolescent issues in the post-war context were to address 'risks' and to provide 'protection'. These were largely framed as the regulation of adolescent girls' (and boys') questionable or immoral behaviour. It was also striking that the adolescents themselves demonstrated an internalisation of emergent social norms and normalised the processes by which their morals and behaviour were socially regulated. If we consider that social and moral regulation includes not only disciplinary power but also self-regulation, then the two dimensions of external regulations (exercised through advice, criticising, punishment, restricting behaviour and mobility and slander) and self-regulation can be seen to be a part of the same phenomenon[17].

Adolescent girls' transition from childhood to adolescence is marked by changes in physical appearance and the type of cautions they received. Common cautions given to them, especially by their mothers, focus on avoiding sexual interest from men – by dressing and conducting themselves appropriately, not staying out late, not idling on the road, not hanging out near the front gate and ensuring that they lock the doors of the house when alone, which is frequently when mothers work in the paddy fields or outside of the home. Girls therefore tend to consider growing up as a stage when they need to be more careful about their behaviour in public and more concerned for their protection. Girls internalise these rules and accept the *restrictions as normal*. Some girls also spoke about beginning to be noticed more by boys and receiving love letters. They seemed to take pride in saying that they did not respond to these and informed their parents about them.

Therefore, adolescence for both girls and boys is the stage when they begin to be subject to both social and moral controls – externally through family and community, and internally through self-regulation. Society was seen as full of risks, where they could fall prey to sexual interest and abuse, pornography, smoking, as well as rumour, slander and neighbourhood gossip. This same society was also the enforcer and regulator of 'protection' and 'normal behaviour', with Civil Protection Committees further constraining the moral and social lives of adolescents.

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17 As Foucault notes in the History of Sexuality Vol. 1, (1978), normative and moral discourses work through their subjects, so that they become not only easily regulated but also self-regulating. Moral regulation privileges dominant modes of being socially desirable and legitimate. The 'normal' defines and limits the choices available to individuals, and thus they, 'become embedded in and embrace the very processes which restrict possibility in [their] lives' (Adams, 1997: 12).

This strong moral code, which did not acknowledge the realities of adolescent lives, pushed young girls to drop out of school or even attempt suicide. Societies' lack of recognition of the transitional stage of adolescence was illustrated by a Moulavi (a Muslim religious leader) in a KII:

Recently there was a suicide of a boy (16 years old) because of a love affair. The girls are usually stopped from going to school after their O/Ls and they are married early by the age of 16-18. There is no space given to boys and girls to share their feelings or aspirations. The elders stick to their wishes and push the children to do that.

Source: Moulavi and Director of a Muslim school

Despite a policy environment where state and non-state service provision aim to promote equal access to services, the moralistic and gendered attitudes of many service providers influence the nature of service delivery otherwise. What was very clear from the outset is that the gendered attitudes of service providers mediate service provision for adolescent girls. Below are some illustrative examples that are among the experiences of adolescent girls in the community studied:

- *Concerns around girls' protection and respectability*

Access to vocational training and tuition for adolescents, especially girls, is mediated by protection concerns. Girls' access to vocational training or tuition, especially in the A/L class, is limited if it requires travelling too far or if an adult caregiver cannot accompany them. The fact that the tuition classes are mixed spaces, allowing for the possibility of love affairs, also stops parents from sending girls. Even if parents are supportive, there is social pressure and criticism if girls are allowed to travel outside of the community to pursue wider educational options. In youth-focused spaces, particularly in the Muslim communities, the boys themselves do not allow girls to participate.

- *Girls more often penalised for disregarding moral codes*

The School Disciplinary Committee of the local school (comprising the teacher in charge of discipline and a few other experienced teachers) handles issues related to adolescents' conduct in school, including romantic relationships. If an adolescent girl and boy are noted as having a love affair, they are advised by the disciplinary committee to focus on their studies instead. If it still continues, the parents are informed and if the parents' advice too is not heeded, one or the other of the children was asked to leave the school. Most often it is the girl who is given a leaving certificate.

- *Using the 'best interest' of the child to challenge hindering notions of respectability*

There is no legal barrier or official rule to prevent girls who have dropped out of school due to sexual abuse or pregnancy from being re-admitted. However, they are often prevented by the gender norms of school authorities. The schools sometimes ask for guarantors to vouch that the adolescent will behave well and will not negatively influence other students. A Probation Officer in Charge (POIC), in Stage 1 of the study, recounted examples of how such barriers need to be overcome in the best interests of the affected adolescent (see Box 8).

Box 11: Overcoming barriers to continued education of adolescent girls

In one incident, a 15-year-old girl was abused by her father. Her mother was working abroad and on the request of the grandmother who was supporting the girl, the POIC office found her a safe home in a distant location. The grandmother wanted her granddaughter to complete her school education. A school was found in a different DS division where the grandmother had a trusted family with whom the girl could stay safely. The school principal refused to admit the girl, but the POIC used his legal authority to have her admitted to the school and he also provided her with funds to purchase school material and uniforms so that she could attend the new school with dignity.

In another case of incest, a teenage girl was abused by her older brother, which was discovered when she got pregnant. The POIC office helped the girl to live in a safe home and deliver the child. On the request of her mother the child was given up for adoption and the girl, after some time, was helped to resume her education in a new school.

These interventions underscore the personal and official capacity of officials to understand how stereotypical norms affect adolescents and to challenge discriminatory service delivery in order to improve adolescent girls' rights to access services.

- *Pinning the blame on women and missing the issue*

The KIIs and FGDs in Stage 2 underlined the tendency of service providers and child protection systems to criticise mothers who migrate and see it as the main reason for problems related to adolescents. For instance, the principal of the school in the research location said that 84 children out of the 428 students in the school had mothers abroad as migrant workers. According to him, not only were these children cared for less in terms of cleanliness, interest in their school attendance and performance, but this was also behind dropping out and early marriage. Service providers' eagerness to blame mothers who migrate overshadowed the need to look for options to support these children in the absence of their mothers. That these children's lives were riven with domestic and economic issues, as discussed by adolescents in the IDIs of Stage 1, was not given due consideration and there was little analysis on why all the available services did not provide adolescents with the support they needed.

- *Social priorities contradicting adolescent girls' right to access services*

In the Muslim community, religious institutions play a crucial role in mediating in situations of sexual abuse and early pregnancy. The typical response is to instruct the man to marry the adolescent girl. Even in cases of abuse or rape, the *Ullama Sabhai* or the Mosque Sammelanam (the joint committee of all the mosques in the division) push for marriage as long as the girl has reached puberty at the time of the abuse. According to a Muslim religious leader, only in cases of incest would the Police be informed if at all. The *Ullama Sabhai* are consulted regarding the incidents of abuse of Muslim girls, even when these are reported to the police. This creates contradictions between rights discourses, especially rights to access services freely, and family and social priorities.

- *Fear of being reprimanded, discouraging access to services*

There was fear among adolescent girls and their families about disclosing pregnancy. Service providers raised this as a common issue in the Muslim community where families often hide sexual abuse, incest and pregnancies that result. The health sector has mandatory reporting requirements of underage pregnancy to POs if there is no marriage registration. In the case of hospital admissions due to complications after abortions, the health sector also has a mandatory requirement to inform the police as abortion is illegal in Sri Lanka. POs identified abortion among adolescents as a serious concern in the research areas. Because adolescent girls were hiding pregnancy and having sub-standard abortions, the hospital had started a process of compulsory checking for pregnancy with or without consent from the patient. While medical treatment is never denied, according to health sector service providers, the compulsory reporting makes adolescents and their caregivers very nervous about accessing services.

In most of the abuse cases, the perpetrators are men they know, such as akka's (sister's) husband, sitappa (father's brother), or mama (mother's brother), and when this happens, families don't like to expose the pregnancy or take legal action. They prefer to make the girl have an abortion or deliver the baby in another area and give the baby up for adoption. If they come to the hospital we have to report it to the police, probation, or the GBV desk.

Source: Valaichenai Hospital FGD

So although health care is available, it is not particularly sensitive to the fears of adolescent girls or their families, nor does it provide a sense of confidentiality or support for them to choose options in their own time. This discourages some families from accessing services to ensure the health and safety of the pregnant teenagers. This also highlighted the challenges in responding to these situations through a legal/rights framework that gives adolescent girls little space to decide on options when in situations that are not acceptable in the socio-cultural context. Respect and understanding of the views of adolescent girls and their families in such situations would encourage them to access health services when in need, without fear of being reprimanded.

- *Well-intended service mechanism priorities conflicting with children's emotional wellbeing*

One of the strategies the school in the studied community has adopted to respond to dropping out is to visit the homes of these children with the police. As one teacher explained:

We take measures with the help of the police to visit each village on Friday to check for drop-out children and bring them back to school. The children will get scared of the Police and they will start coming to school. We do not have any choice because when the children drop out from school there is immense pressure on us from the Department and Ministry and to safeguard ourselves we have to take measures like this. We know children will be affected mentally by this but we do not have any other choice.

Although their intentions were good, then, the school was also aware that it could be counter-productive and could impact negatively on children's wellbeing.

These examples illustrate that service provision mechanisms responded to adolescents' issues, especially adolescent girls' issues, by viewing them as symptomatic of the adolescents' or their families' failure to adhere to socially acceptable conduct. Policies and regulations pertaining to service provision did not discriminate against these adolescents. But individual service providers' stance on gendered values and notions of respectability influenced whether the services were given and how. As illustrated above, one school principal refused to admit an adolescent survivor of sexual abuse but the POICs broader understanding of children's rights and the issues faced by adolescents helped the girl to resume her school education.

These examples also highlighted the expectation that social issues affecting adolescents would be reduced through service provision mechanisms. Service delivery typically aims to reduce the outcome of the social issue in question: i.e. reducing the number of school dropouts, teenage pregnancies, abortion-related complications and early marriages. In order to assess progress on this, service delivery mechanisms at all levels are required to collect and monitor statistical data on school drop outs, early pregnancies and so on. This influences service providers to be judgemental in their responses to affected adolescents, even as services are not denied. Eagerness to report reductions also influences some service providers, such as schools, to misreport on the actual nature of problems. For instance, a student could be largely absent from school but would not be reported as a dropout if period of absence was less than 41 consecutive days. So students attend school only a few days a month, or be absent for several weeks during harvesting season or during heavy rains, are not given due consideration or help to resolve their issues. Measures that monitor the symptoms of the issues only hide the problem and completely miss the realities of adolescents' lives. Thus, well-established service mechanisms, particularly in health, education and child protection sectors, fail to reach out effectively to adolescents' struggling to deal with the adversities of their lives and with the challenges of the transition from childhood to adolescence.

6 Impact of services on adolescents' protection and wellbeing

Overall, the discussion so far highlights a paradox in the services accessible to adolescents: that despite an abundance of services in the area, these services are unresponsive or distant from those adolescents in particularly difficult circumstances who most need support. Adolescents have access to essential services such as health, education, vocational training and protection through the state sector, with some services supplemented by NGOs. Spaces for social connections and participation are also provided through NGO interventions. Three key features of this service provision determine the level to which these actually respond to the needs and challenges of adolescents, many whom are grappling with a range of adversities:

1. These services are general and not specific to adolescents – they are for patients (in hospitals), children (in schools) or youths (in vocational training). The particular stresses of the adolescent years – the transition between child and adult – are not given special consideration.
2. Service provision works with one predominant understanding of what a child is and does not consider the spectrum of identities and roles that many adolescents in the studied communities occupy.
3. Although services are not denied to adolescents who do not subscribe to the role of the typical child, and these adolescents are supported through health and protection crises, the service providers are strongly critical of deviations. This criticism impacts negatively on adolescents' self-worth, causing them and their families stress. At times they devise coping mechanisms by rejecting services or by using the 'deviant' identity to challenge norms.

This can be seen in schools that lack innovative responses to engage with and encourage students who lag behind in their reading and writing skills and are therefore unable to meet learning outcomes in a range of subjects. It is also seen in schools discouraging adolescent girls from re-joining after abuse or pregnancy, and in health services that respond to teenage pregnancy as a form of bad behaviour. It is seen in formal and informal mechanisms that control girls' behaviour to protect them from abuse, and it is evident in the lack of initiatives to engage with school dropouts, working children and teenage mothers, despite their potential to gain significant benefits from social interactions such as those in children's clubs. Service providers also demonstrate overt or covert judgemental responses towards adolescents who do not comply with the social expectations of children. There seems to be a discrepancy between service provision that discriminates in favour of 'good' children and the complex social and family issues that drives many adolescents to make difficult or non-typical choices as they grow up.

IDIs and case studies conducted with adolescent girls in Stage 1 of this study highlight how service providers' lack of responsiveness to adolescents and the specific challenges they face can be detrimental to their wellbeing. For example, an education system that does not engage with working adolescents and married adolescent girls to continue their education or develop employable vocational skills results in them stagnating in low-income jobs and economic strife. Adolescent girls improve their standing in the family if they are able to contribute to the family income. Stage 1 of this research revealed that adolescents, when overwhelmed by adversity, tend to lower or give up on their aspirations for a 'good education' and a 'good job,' which they identified as essential for their wellbeing.

Service provision gets distanced from adolescents who need it most when it is unresponsive to the challenges they face in adverse circumstances and when it defines them according to value-laden social understandings of family, marriage and children. This further perpetuates intergenerational cycles of domestic violence, poverty, lack of formal education and early marriage.

7 Conclusions and options for the future

Service mapping highlighted that there are a variety of services in the Batticaloa district but that most do not have mechanisms to deal particularly with adolescents and are therefore unable to help them resolve or cope positively with the complex issues they may face.

The following key issues require attention in the future development of services:

Early identification of adolescents at risk: The absence of mechanisms to identify at-risk adolescents' problems early was notable. Well-established services at all levels tend to respond to negative outcomes (such as school dropouts, early marriage) or crises (such as deliberate self-harm) after they occur.

Empathetic understanding of adolescents to strengthen their sense of being supported: Across all levels of service provision, there was a tendency to consider adolescence as a risky stage where children can make choices that harm cultural and societal norms. Service provision thus operates from a moralistic standpoint, often adopting controlling and punitive responses to deal with adolescents' issues. This results in the reluctance of adolescents and their families to access services when dealing with difficult choices. As highlighted in Stage 1 of this study, adolescents felt supported by service providers (often a teacher in school) when the service provider maintained confidentiality and was sensitive to their priorities and concerns. Adolescents looked for trusting relationships with adults, but they did not easily find them in the services available, which treated them as if they were younger children.

Support to adolescent girls in negotiating conflicting social priorities: The issues affecting the protection and wellbeing of adolescent girls are further complicated by the conflicting messages that adolescents receive from society. For instance, there is a value placed on 'being educated' as a means to improve socio-economic status. Mandatory school attendance policies encourage this pursuit and a sense of achievement to be gained from good results. But the lack of support for students who lag behind in school discourages them from continuing. There is also a social permissiveness around girls marrying early. Adolescent girls feel that marriage gives them respect and a status that their unmarried peers don't have. Families and community believe that marriage protects girls' honour, and within the Muslim community there is a belief that girls live longer if they have babies early. Adolescents' interest in intimate relationships also makes marriage an appealing choice. Service provision responds to the outcome – married or unmarried teenage pregnant girls – through health and child protection mechanisms, but the study underlines the need to extend these to have a constructive dialogue with adolescents and engage them in process that helps them to explore the stage of adolescence. In parallel, services that promote their productive engagement in social activities, space for creative expression and safe recreational opportunities would promote a positive outlook on life and strengthen their resilience.

Acknowledging adolescents' diverse identities and how they contribute to self-worth; and providing safe spaces for adolescents to discuss issues openly: Adolescents' sense of self-worth, while culturally defined and reinforced through family relationships and community norms, is also negotiated by adolescents themselves through their responses to the circumstances they face. In a society that puts a high value on education, academic achievement contributes to adolescents' sense of self-worth. Other choices made by adolescents, however, are more problematic. For instance, adolescents achieve a level of social acceptance and status through work and through marriage, which increases their bargaining power within the family. Adolescents experience the stress of these roles in a society that considers them legally as children. This

leaves a gap between their experiences as adults (being married or working) and how they are treated in terms of service provision. There is little space within the many services, even in schools, for adolescents to talk openly about their diverse identities or explore their aspirations, self-worth and self-esteem.

Space to explore skills and talents: Another gap is the absence of spaces for young people to explore skills and talents, share responsibilities and exercise agency and participation. Although several NGOs operate children's clubs, these reach out to a limited number of adolescents. Girls' participation is further limited by social and family restrictions on their mobility and, in Muslim communities, restrictions on mixing with non-family males. Self-regulation by girls – limiting their social interactions based on social norms – restricts their access to social support and to wider life choices outside their familiar environs.

Disruptive family relationships – an unaddressed issue affecting adolescents: A gap in formal service provision is the notable lack of services that support close family relationships, unless children in crisis are brought to the attention of health or child protection services. Many adolescents experience disruptive family relationships, parents separating, or being compelled to live with grandparents, other relatives or even non-relatives and sometimes facing ill- treatment there. Community-based mechanisms are too focused on supporting children in crisis through mechanisms such as the VCRMC. There is a lack of formal and informal mechanisms that work with a broader understanding of family and offer children support in dealing with economic, social and emotional stresses when family relationships and support systems deteriorate. Adolescents would benefit from systems that are location-specific, organic and community based.

Monitoring data that hides the realities of adolescents' lives: Statistics related to children's education, protection and health are monitored at divisional, district and national levels to focus interventions and promote achievements. But in the absence of effective mechanisms to deal with issues in depth, there is a tendency to misreport statistics – especially by schools. This hides the real picture and denies makes it hard to systematically identify causal factors and to support affected students.

A child-centred, rights-based approach is challenged by attitudes and misses out adolescence: The policy and practice of state and NGO service provision is to respond through a child-centred or rights-based framework. But this is challenged by prevalent moralistic standpoints, to which most service providers also personally subscribe, and the attention that should be given to adolescence as a transitional stage of life is overlooked.

Need for openness, flexibility and innovation in service provision: There are several features that have emerged in this study as imperative in reinforcing adolescents' (and especially girls') abilities to cope positively and resiliently with multi-dimensional stresses in their lives. These includes an openness and flexibility in understanding issues and approaches to service provision; innovation in service provision mechanisms to deal with the varied stresses of adolescents' lives; integrated services across sectors that facilitate holistic and consistent services; and proactive mechanisms that reach out to adolescents to identify their issues early on.

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