

***Above the Law: Violations of
Women's Reproductive
Rights in Northern Sri Lanka***

***A report by The Social Architects
Sri Lanka
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TABLE OF ACRONYMS AND ABBREVIATIONS	3
EXECUTIVE SUMMARY	3
1 INTRODUCTION	6
1.1 TYPES OF CONTRACEPTIVES IN THIS REPORT:*	8
1.2 CONTRACEPTIVE IMPLANT, JADELLE	11
2 FACT-FINDING, SEPTEMBER 2013:	12
2.1 METHODOLOGY	12
2.2 CHALLENGES	14
2.3 FINDINGS	15
3 RECOMMENDATIONS	36
3.1 TO THE GOVERNMENT OF SRI LANKA	36
3.2 TO CIVIL SOCIETY	36
3.3 TO BAYER, THE MANUFACTURER	37
3.4 TO THE INTERNATIONAL COMMUNITY	37
Table 1: Acronyms and Abbreviations	3
Table 2: Types of contraceptives in the report.....	8
Table 3 Map of Killinochchi	13
Table 4: Assessment of Compliance with Jadelle Counseling Requirements	27
Table 5: Compliance with Pre-insertion instructions.....	32
Annex 1: Demographic Data	
Annex 2: Jadelle Patient leaflet	
Annex 3: Interviews	
Annex 4: Jadelle Card- Proof of Implant	
Annex 5: Post Insertion Health Record	
Annex 6: Photos	

Table of acronyms and abbreviations

Table 1: Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DS	Divisional Secretariat
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IDP	Internally Displaced Person
GoSL	Government of Sri Lanka
GTI	Genital Tract Infection
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUCD	Intrauterine copper devices
Kg	Kilogram
LKR	Sri Lankan Rupee
LNG	Levonorgestrel
MOH	Ministry of Health
RDS	Rural Development Society
RHA	Rural Health Assistant
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TSA	The Social Architects
UNFPA	United Nations Family Planning Association
WRDS	Women's Rural Development Society

Executive Summary

This report, TSA's fourth, outlines the findings of the organization's September 2013 field mission on coercive contraception clinics in Kilinochchi District. In early September of this year, activists in Kilinochchi discovered that public health workers had administered the sub-dermal contraceptive implant, Jadelle, to women from Veravil, Keranchi, and Valaipaddu during a nutrition clinic. After publishing accounts from these women, TSA traveled to Kilinochchi for an in-depth follow up investigation. This report confirms that public health workers used coercive tactics to convince women to accept Jadelle. This egregious disregard for medical ethics and protocol constitutes serious violations of a woman's rights to informed consent, reproductive autonomy, and health.

TSA visited the Veravil, Keranchi, Valaipaddu, Umaiyalpuram, and Malaiyalapuram villages, where Internally Displaced Persons (IDPs) have begun to rebuild their post-war lives. TSA interviewed twenty-three women ranging in age from fifteen to forty-three, members of the Ministry of Health (MoH), Kilinochchi, field level health workers, and community leaders. TSA worked on a very tight deadline and was under constant military surveillance throughout the course of this research.

The report includes eight conclusions: 1. Women in these villages lack adequate access to primary care. 2. Women lack adequate access to quality contraceptive services. 3. Public health workers asked women to come to a government sponsored nutrition clinic under false pretenses. 4. Government health workers coerced women into taking the implant. 5. Government health workers did not provide adequate counseling and women did not give full and informed consent. 6. Government health workers failed to conduct adequate medical pre-screening and to provide post-implant care instructions. 7. Public health employees failed to provide information to women who accepted the implant. 8. Women feel unsafe asking doctors questions. Government employees have told their subordinates to remain silent on this issue –perpetuating a culture of impunity.

Finally, this report urges the Government and civil society organizations to conduct a comprehensive investigation, to hold reproductive health and rights trainings for women and public health employees, to provide information on the implant in Tamil, to ensure adequate staffing at the field level, to develop a complaint mechanism for the public health system, to create a checklist for implant insertion, and to meet with women in these villages to explain removal, steps taken for accountability, and alternate forms of contraception.

The World Health Organization (WHO) and International Conference on Population and Development (ICPD) define reproductive rights as: “the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of [discrimination](#), [coercion](#) and [violence](#).”

In light of these fundamental rights TSA reiterates: Women have a right to understand the benefits and potential side effects of all available contraceptive options that they may require at different stages of their lives. They have the right to accept or deny any form of contraception at any time. Removing the implant requires a medical intervention (unlike pills), therefore reducing a woman’s control over her reproductive self-determination. Contraceptive counseling with an emphasis on free choice is especially important in conflict zones where women already have fewer options, inadequate information, and limited access to primary health services including contraception. Misleading women into hospital visits, presenting false medical

information, and the failure to ensure a woman's right to make an informed, meaningful choice amounts to coercion and force – clear violations of women's autonomy, well-being, dignity and bodily integrity.

Coerced medical procedures constitute cruel, inhuman, and degrading treatment under international law.

1 Introduction

In September 2013 reports from Kilinochchi District described coercive population control policies in three villages – Veravil, Keranchi, and Valaipaddu. The Social Architects (TSA) released an article on this issue and has subsequently followed-up with this report.¹ For this particular project, a fact-finding team included reproductive rights specialists, human rights experts, and local activists. The organization spoke with women in these villages, neighboring villages, local doctors, village level leaders, community leaders, and doctors at the Ministry of Health (MOH) in Kilinochchi. After conducting this fact-finding mission, the team can unequivocally conclude that government health workers coerced women into accepting Jadelle, a progestogen-only subdermal implant (POSDI) manufactured by Bayer.

Women's and minority rights activists in Sri Lanka are especially wary of population/family planning policies that may target specific populations, regions, or communities. Additionally, members of the Sri Lankan armed forces (Army, Navy, and Air Force) receive an incentive of Sri Lankan Rupees (LKR) 1 lakh (about 600 Euros) for their third child.²

Also, some religious groups have protested the Jadelle implant in southern Sri Lanka. In this context, reports of coercive family planning practices in conflict-affected communities – which remain very vulnerable – demand an investigation and accountability. In any context, women have a right to reproductive autonomy, bodily integrity, informed consent, and health. Violations of these rights also demand a thorough investigation and immediate action.

¹ See <http://groundviews.org/2013/09/13/coercive-population-control-in-kilinochchi/>

² <http://www.treasury.gov.lk/depts/fpd/budgetspeech/2013/budgetSpeech2013-eng>.

Above the Law, TSA's fourth report, provides background information on these villages, information about the contraceptive implant Jadelle, the methodology the fact-finding team has used, interviews from the field, conclusions, and policy-oriented recommendations for the government and other stakeholders.

Basic facts about Umaiyalpuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu Villages

With a population of 1,812, Malaiyalapuram is the largest of the villages. Veravil, with a population of 627 is the smallest.

Only one of the five villages, Keranchi, has a market. All five villages have community halls, preschools and primary schools. Veravil is the only town that has a hospital, but all five locations have primary health centers.

Community members in these five Kilinochchi towns³ rely principally on agriculture and fishing to make a living. Nonetheless, poverty and unemployment are rife in all five locations. In addition, community members cope with poor infrastructural facilities – including roads – and a lack of transportation.⁴

These war-torn areas also suffer from inadequate access to education and malnutrition. Though a range of humanitarian organizations – including United Nations (UN) agencies, CARITAS and Swiss Labor Assistance – work in this area, people in these villages require additional assistance.

Families in these villages have recently resettled from Internally Displaced Persons (IDP) camps. Throughout the war, these families experienced death, disappearances, rape,

³ Please refer to Annex I for more information on demographic data.

⁴ Readers will note a discrepancy between family sizes for Veravil, Valaipaddu and Keranchi, when compared to the original TSA article that was published in *Groundviews*. Population data for this report has relied on information provided by various Grama Sevaka officials. In TSA's original piece, the organization relied on information provided by RDS officials.

torture, starvation, and constant displacement. Today, the families live in partially constructed homes. Many of the men make a meager living as fishermen. Malnutrition plagues many of the families who struggle to feed their children.

Dr. Karthikayan, Regional Director of Health Services, told the fact-finding team that Sri Lanka's unmet need for contraception, defined as the number of married women aged fifteen to forty-nine who do not use contraception even though they wish to delay the birth of their next child or wish to prevent pregnancy, is only 4%. However, for women who live in Umaiypuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu the unmet need is at 30%.

The fact-finding team met with a high ranking Rural Development Society (RDS) member who reported that families in Veravil and Valaipaddu usually have five to six children and that families in Keranchi have about four to five children on average.

1.1 Types of contraceptives in this report:*

*Additional forms of contraception exist, this table only defines contraceptives available in the public sector in Sri Lanka. This list is not intended to provide exhaustive information about each method, but instead serves as an introduction to the forms of contraception discussed throughout the report.

Hormonal contraceptives (the implant, injectables, birth control pills) can only be used by women and have a higher risk of side effects including venous clots and blood clots. Non-hormonal contraceptives (condom, IUCD, sterilization, traditional methods) can be used during breast feeding. When a woman wants to have another child, fertility returns faster after a woman discontinues a non-hormonal contraceptive.

Table 2: Types of contraceptives in the report

Condom	A barrier method of protection. The male condom is placed on the penis during intercourse and blocks semen from entering the partner's body. The condom prevents pregnancy and transmission of STIs and HIV/AIDS. When used correctly every time, the condom is 98% effective
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	for preventing pregnancy.
Implant	A hormonal form of contraception. A trained doctor or nurse inserts two silicone rods under the skin of a woman's arm. The contraceptive implant (referred to as Norplant or Jadelle) releases levonorgestrel (a synthetic progestogen) hormone into the woman's body over five years. The implant prevents ovulation, thickens the cervical mucus, and thins the lining of the uterus, making it unlikely that an embryo will attach. The implant is 99% effective for up to five years. A doctor can remove the implant at any time.
Injectables/Depo-provera	Depo-provera is an injectable, hormonal (progestogen-only) form of contraception. The hormones thicken the cervical mucus, make the uterine lining light, and prevent ovulation, making fertilization almost impossible. Depo-provera is 99% effective against pregnancy. The injection may be used during breast-feeding, but women are advised to wait six weeks. The injection is effective for three months.
Loop/Intrauterine copper device (IUDC)	An IUCD is a non-hormonal form of contraception. A trained doctor or nurse will insert a copper T-shaped device into the uterus. The IUCD renders sperm non-viable and prevents fertilization. The IUCD can also be used as a form of emergency contraception for five days after unprotected sex. There is a hormonal form of IUD, but it is unavailable in Sri Lanka. The IUCD is 99% effective for prevention of pregnancy.
Oral Contraceptive Pills/Birth control pill	The combined oral contraceptive pill (available in Sri Lanka) includes two hormones, estrogen and progestin. A woman will take the pill every day at the same time. The pill prevents ovulation. If used perfectly, the pill is 99% effective. Emergency contraceptive pills are also available in Sri Lanka and may be taken within 72 hours of unprotected sex to

	prevent pregnancy.
Sterilization	<p>During a male sterilization, or vasectomy, the doctor cuts the vas deferens, or tubes that carry sperm out of the body. Accordingly, sperm cannot enter the partner's body. A vasectomy is 99% effective and usually reversible. During a female sterilization, a doctor will cut and tie or cauterize the fallopian tubes to prevent the egg from fertilization. Tubectomies cannot be reversed. Female sterilization is 98% effective. In Sri Lanka, a woman must be over 35 and have five children to qualify for a tubectomy.</p>
Traditional methods/Behavioral	<p>Non-hormonal methods that prevent sperm from entering the partner or time sexual intercourse with a woman's cycle. When used perfectly, these methods can be 97% effective. In reality, these methods are about 85% effective. Methods include: abstinence (refraining from vaginal intercourse), withdraw method (ending sexual intercourse before ejaculation), rhythm method (timing sexual intercourse to match the least fertile days of a woman's cycle), lactation (if a woman exclusively breast feeds for six months and has not resumed her periods, a woman's natural post-delivery infertility will be 98% effective in preventing pregnancy).</p>

1.2 Contraceptive Implant, Jadelle

As noted, Jadelle is a progestogen-only subdermal implant manufactured by Bayer. The implant requires a minor surgical procedure wherein a trained doctor or nurse uses local anesthesia to insert two flexible rods in a woman's upper arm. The rods release levonorgestrel into the body. Jadelle provides contraceptive protection for five years, but the implant can be removed at any time. The hormone stops ovulation and thickens the cervical mucus, making it impermeable to sperm. The implant is completely reversible and according to the manufacturer's Jadelle Patient leaflet for New Zealand⁵, women who stop using Jadelle can become pregnant as rapidly as women who are not using contraception.

According to the manufacturer, Jadelle "may be used by all healthy women who do not wish to get pregnant." Women who suffer from "active thrombophelibitis, genital bleeding, acute liver disease, malignant liver tumor, known or suspected breast cancer or other hormone dependent cancer should not use Jadelle. Women who are pregnant should not use Jadelle and if a woman becomes pregnant she must immediately remove the implant.

After a woman receives the implant, she may feel tenderness, swelling, bruising and/or bleeding at the insertion site. The insertion site should be kept dry for two to three days and the woman should refrain from lifting heavy objects. The hormonal drug is likely to impact women's menstrual cycles, which should stabilize after a year. Women might experience prolonged bleeding during first few months, bleeding/spotting or no bleeding for several months. Many women will experience some adverse events; these include: headache, nervousness, nausea, acne, vaginal discharge, pelvic pain, weight changes, genital itching, and skin complaints. Women are instructed to contact a doctor if they experience severe lower abdominal pain, heavy vaginal bleeding, arm pain, pus

⁵ Please refer to Annex II.

or bleeding at the insertion site, indicating infection, expulsion of an implant, episodes of migraine, repeated severe headaches or blurred vision, delayed menstrual cycle after a long time of having regular cycles, jaundice, depression or visual disturbances.

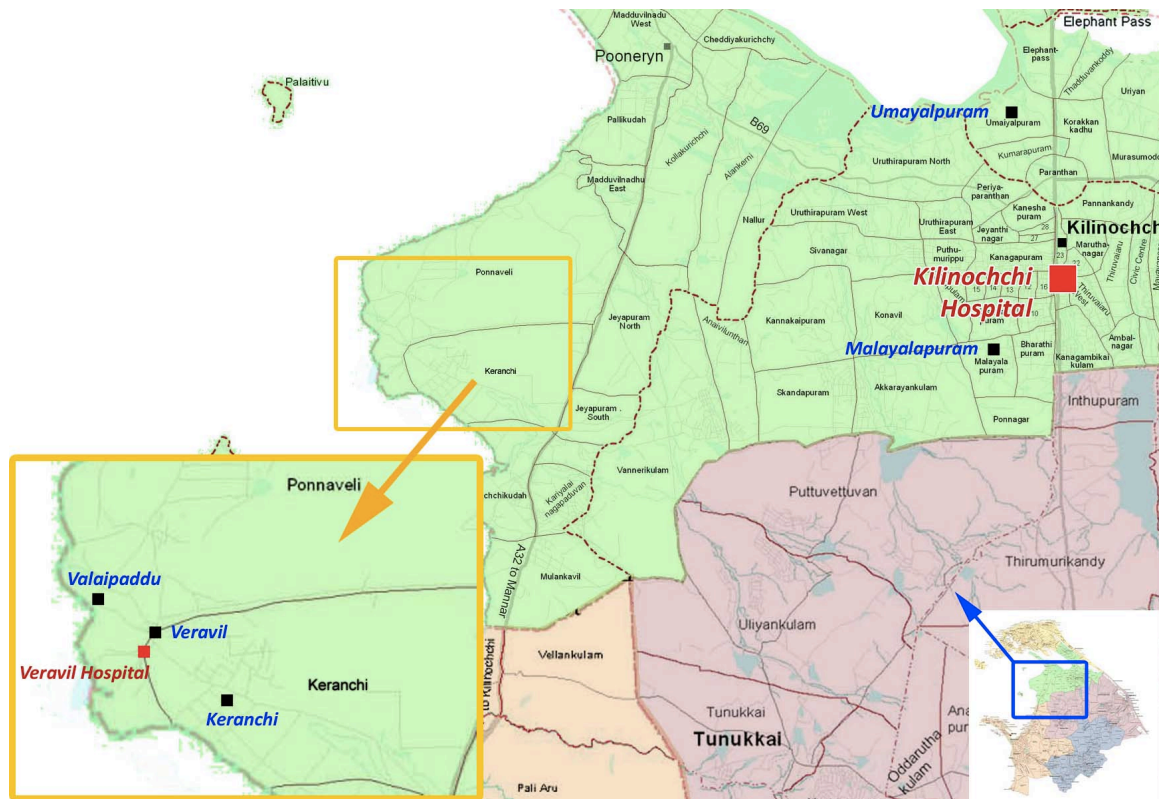
Finally, the post-insertion product information states that women should have yearly follow-up medical visits “as part of [an] annual gynecological check-up.” The post-insertion instructions also tell women to “read the package insert carefully. In all situations where the reliability of Jadelle is reduced (like when a rod is missing) additional contraceptive precautions are required.” It is important to note that women in these villages do not have access to “annual gynecological check-ups” and that not a single woman received a Jadelle leaflet, the package insert *or any written information about this contraceptive implant*.

2 Fact-finding, September 2013:

2.1 Methodology

In September 2013 a team of reproductive rights activists, health rights experts, lawyers, human rights advocates, and local community activists visited several villages in Kilinochchi district. The team spoke to women in three of the four Divisional Secretariats (DS). In DS Kandavalai the team visited Umaiyalpuram, in DS Karachchi the team went to Malaiyalapuram, and in DS Poonakary the team visited Keranchi, Veravil, and Valaipaddu villages.

Table 3 Map of Killinochchi



In Veravil, Keranchi, and Valaipaddu the team met with sixteen women who had been called for a “nutrition clinic” on August 31, 2013. Some of these women had received the implant while other women refused it. Local volunteers identified many of the women, but the fact-finding team also spoke to women randomly. The team interviewed community leaders, a local health expert, and a volunteer health worker.

In Malaiyalapuram and Umaiylapuram the team spoke to seven women who had received the implant within the past year and to women who had been pressured to accept the implant. Local volunteers and the women themselves identified women for interviews in these villages. The team also spoke with community leaders.

The team asked each woman standard background questions about her age, number of children, age of children, and whether the women used spacing methods (condoms, intrauterine copper devices (IUCDs, also known as the loop), injectables, or traditional methods). The team also asked the women about their general health. The team asked

the women to describe the day they received their implant or the day they were initially approached regarding the implant. After the women narrated their experiences, the fact-finding team asked questions using Jadelle's training manual for family planning and information from the manufacturer to determine if government medical staff had followed basic guidelines for counseling, screening, informed consent, and after-care. The team conducted the interviews in Tamil with simultaneous English translation.

Because the military and local authorities have paid close attention to this story and even called the respondents personally, identifying details including exact age, number of children, and profession have been omitted from this report. Each woman has been identified with a number.⁶

The fact-finding team also spoke to government employees at the Ministry of Health (MOH) including Dr. Karthikayan, Regional Director of Health Services, and MOH employees in Colombo, as well as with reproductive health experts in Sri Lanka.

2.2 Challenges

Timing: Due to the controversy the TSA article⁷ inspired, the organization wanted to issue this follow-up report as quickly as possible. This report recommends a thorough investigation and health survey in these communities with participation from the government and civil society.

Paucity of data: The fact-finding team struggled to find basic health indicators for people living in Kilinochchi. For years, the Government of Sri Lanka (GoSL) has failed to provide

⁶ Please refer to Annex III for the interviews. The fact-finding team spoke to more than thirty people. Out of that, twenty-five are women who have been affected by the Jadelle implant. However, some interviews have not been included in this report – for security purposes – as per the request of interviewees.

⁷ <http://groundviews.org/2013/09/13/coercive-population-control-in-kilinochchi/>

information on populations living in the North and East. When the fact-finding team asked the Kilinochchi MOH for data on the population, it was told to seek permission from the MOH Colombo. While the information we have shows immense disparities between villages in Kilinochchi district and the rest of Sri Lanka, it is impossible to fully assess reproductive health care in the north without adequate data. The secrecy surrounding health indicators from the North also makes it difficult for civil society organizations to effectively design and implement strategies to ensure access to fundamental entitlements.

High Levels of Militarization: The Sri Lanka Army (SLA) followed the fact-finding team through some villages and recorded the team's vehicle number. The team was under constant surveillance throughout the course of this research. The overwhelming military presence also contributes to a culture of fear surrounding human rights activities (see below).

Fear of speaking: Military personnel, government employees, and direct superiors had contacted many women and health workers to forbid them from speaking to journalists or investigators. Even Dr. Karthikayan, a senior district MOH employee told the fact-finding team that he could not speak with journalists. Many women were scared that local hospitals would refuse to treat women from these villages who spoke to "outsiders" about the implant. Additionally, the reports on this issue, follow-up home visits from doctors for the first time in their lives as long as they can remember, lack of information about this implant, and sustained international attention has made some women afraid that the implant is dangerous or something that could prevent them from ever having children. While the team absolutely abstained from giving women medical advice, it did reassure many concerned women that this method of contraception is relatively safe, effective, and reversible at any time.

2.3 Findings

The fact-finding team interviewed Dr. Karthikayan, Regional Director of Health Services. The team also spoke to twenty-three women who received the implant in the last year or who refused the implant in the last year. Finally, the team spoke to community level leaders, one village health worker, and one local health expert.

During the course of this research, the team uncovered significant denials of basic government entitlements and fundamental rights. In place of informed choice rooted in a robust primary care system, a seemingly benevolent team of doctors and nurses pressured, lied, and manipulated some women into accepting the Jadelle implant. The government health workers provided the women with *zero* written information regarding the drug that doctors surgically inserted. Women did not receive post-care instructions or advice on when to seek emergency care. Nurses presented the implant as a mechanism for preventing pregnancy in the case of rape. Women from the villages, health workers, and MOH employees have been instructed to keep their mouths shut in the wake of this gross disregard for good clinical practice.

Women and families in these villages struggle to feed their families and to rebuild their physical, psychological, and social worlds in post-war Sri Lanka. In this context, providing women with an extremely expensive implant – that requires surgical intervention – simply does not constitute a rational health policy. Basic notions of human dignity and gender equality demand access to primary care, including reproductive care, full and informed consent for any medical procedure, and transparency. This section provides an analysis of TSA's conclusions.

1. *Women in Umaiypuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu lack adequate access to primary care, including reproductive health care and contraceptive information and services.*

The women and families in these war-affected communities do not have adequate access to acceptable, quality health services. Keranchi, Veravil, and Valaipaddu do not have a field level midwife and the local hospital only has a doctor who does not provide any reproductive health services. Women have to travel long distances to deliver, to

access health services for their children, and to obtain contraceptive services. Women at times deliver in the ambulance ride between Veravil divisional hospital and Kilinochchi Hospital.

Many women said that they did not report the side effects of Jadelle to a doctor because the hospital is too far away or because they cannot afford to travel. Even if their symptoms (including dizziness, headache and pain) are related to malnutrition or another cause, women and families cannot obtain basic primary care for these issues. For example, Interviewee 1 was suffering from a fever, leg aches, headaches, and dizziness. She has not reported these ailments to a doctor because her family cannot afford treatment. Interviewee 9 has not had her period in over a year and she is afraid that she has a tumor or cancer. She fears that the doctors will remove the implant and will not give any other contraceptive if she complains about her periods.

Every woman in Keranchi, Veravil, and Valaipaddu told the fact-finding team that the doctor's post-implant home visit was the first time a doctor had ever come to their homes. Every woman in Keranchi, Veravil, and Valaipaddu told the fact-finding team that the doctor's post-implant home visit was the first time a doctor had ever come to their homes. These follow up visits took place only after TSA released its article on the clinic in Keranchi, Veravil, and Valaipaddu. It is important to note women who received implants outside of these villages were not lucky enough to have a post-insertion⁸ doctor visits even though a similar health camp took place in Malaiyalapuram just a few days after the Veravil contraceptive clinic.⁹

Families continue to suffer from malnutrition. Interviewee 6 told the team that she struggles to feed her children and, although she has this implant, no one has given her nutritional supplements or assistance to feed her family.

⁸ Please refer to Annex IV for an example of a Jadelle Proof of Implant.

⁹ Please refer to Annex V for an example of a Post Insertion Health Record.

Myriad MOH schemes, national policies, and rural development programs guarantee basic health services to vulnerable populations such as community members in Kilinochchi. At the same time, under the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the GoSL has an obligation to ensure the right of everyone to the highest attainable standard of health (Article 12). The government is legally bound to ensure that health services are adequate, accessible, acceptable, and of high quality. Other binding international conventions like the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) echo the importance of the right to health. In its concluding remarks on Sri Lanka, the Committee for the CRC found,

52. Committee expresses concern that the proportion of GDP devoted to health has been decreasing since 2007. The Committee also notes with concern that although the State party suffers no significant food shortages and provides extensive, free maternal and child health services, maternal under-nutrition continues to be a major challenge, malnutrition affects nearly one-third of children and fourteen percent of children under five suffer from acute malnutrition due mainly to the unequal distribution of services in the regions...

53. The Committee recommends the State party to continue to:

a. Prioritize the allocation of financial and human resources to the health sector with a special emphasis on primary health care, in order to ensure equal access to quality health services by all children including children living in the plantation sector and conflict affected areas...¹⁰

¹⁰ CRC Committee, *Concluding Observations: Sri Lanka*, U.N. Doc CRC/C/LKA/CO/3-4 (2010), available at <http://daccessddsny.un.org/doc/UNDOC/GEN/G10/458/08/PDF/G1045808.pdf?OpenElement>

The government has failed to provide basic primary care services to women and families in the face of national guarantees and binding international law.

2. Women in Umaiypuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu lack adequate access to quality contraceptive information and services.

Without adequate primary care services, women do not have access to the full range of contraceptive methods, related information and counseling.

Many women expressed familiarity with a wide variety of contraceptive methods – condoms, pills, IUCDs, and injectables. However, the public health system controls access to contraception for poor women. Women in these villages have no choice but to obtain contraception from a midwife or to travel long distances to a hospital where their preferred method of contraception could be unavailable. Women have to wait until a trained doctor is available to provide other forms of contraception (IUCD, implant, tubectomy).

Many women specifically stated that they accepted the implant immediately because the doctors had travelled to their village and there was no guarantee they would have access to trained staff or the implant in the future. Interviewee 11 accepted the implant because she was told that a doctor from Colombo was coming and that she would not be able to access this type of contraception again. Other women told the fact-finding team that they could not afford travel to a hospital for contraception, so they accepted the Jadelle implant.¹¹

The Jadelle implant requires a surgical medical intervention from a trained doctor – both for insertion and removal. Women from these villages have been denied their rights to consider all contraceptive choices freely, to discuss their options with a medical professional, and to choose a method that works for them. Instead, inadequacies in the

¹¹ Please refer to Annex VI for some photos of the locations where events transpired.

public health system dictate women's choices and force them to choose the contraceptive method that is most easily accessible. Limiting women's options clearly violates the goals and policies in the MOH Women's Affairs and Women's Charter, the Population Policy Strategy, and the National Policy on Child and Maternal Health 2012.

The Ministry of Health & Women's Affairs Women's Charter enjoins the state to ensure women's right to reproductive rights with information, education, counseling in family planning, the provision of safe family planning devices and the introduction and enforcement of regulations related to safety. The Women's Charter of Sri Lanka provides safeguards for women's rights within the family structure. Article 7(i)(e) gives women the right to "decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." In Umaiyalpuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu, women cannot freely determine the number and spacing of their children; the public health system determines and limits the contraceptive information and services available.

Likewise, Sri Lanka's Population Policy Strategy aims to provide comprehensive family planning information, education, communication and services through government, NGO, and private sector sources. However, the fact-finding team found that women do not receive comprehensive information regarding any method of birth control prior to usage. The policy further aims to improve the quality of service delivery to enable couples to decide freely and responsibly the number and spacing of children. Without adequate midwives, doctors, or facilities, women will not have the information necessary to make a free choice. Here, public health workers "convinced" women to accept Jadelle as the only easily available option. Although the population policy emphasizes the need to focus attention on the unmet needs of IDPs, women in these villages have had to accept substandard contraceptive services as a result of poor staffing, inadequate infrastructure, and a lack of supplies.

Finally, the National Policy on Maternal and Child Health 2012 aims to “enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies.” The rationale for the policy goal is that unintended pregnancies result where a significant percentage of women rely on natural and traditional methods of family planning. The interviews in this report show that awareness and usage of several methods of contraception is high and that many women have a preferred method. Despite these preferences, many women told the team that they could not access the full range of contraceptives because they could not travel to hospitals, their village did not have a midwife, they could not afford to see a private doctor or because doctors were unavailable once they reached a facility. Although the policy aims to meet the demand for permanent methods of family planning, several women who wanted a sterilization surgery, were refused the procedure.

Under international law, the GoSL has an obligation to ensure that women have adequate access to contraceptive information and services. CEDAW guarantees all women in Sri Lanka “access to specific educational information to help ensure the health and wellbeing of families, including information and advice on family planning.” (Article 10h). Moreover, CEDAW Article 16 guarantees a woman’s right to freely and responsibly determine the number and spacing of her children.

When the public health system limits contraceptive services, women suffer disproportionately. Here, the State’s failure to ensure adequate access to contraceptives violates women’s rights to equality and non-discrimination guaranteed in Sri Lanka’s Constitution and CEDAW.

CEDAW General Recommendation 21 states:

“Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must

have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention.”

These services improve the overall wellbeing of communities, a crucial observation for IDP populations. General Recommendation 21 outlines this link:

“There is general agreement that where there are freely available appropriate measures for the voluntary regulation of fertility, the health, development and well-being of all members of the family improves. Moreover, such services improve the general quality of life and health of the population, and the voluntary regulation of population growth helps preserve the environment and achieve sustainable economic and social development.”

In violation of government policies and fundamental rights, women in these villages cannot make *free* choices regarding contraception. Instead, inadequate staff, inaccessible facilities, and insufficient information limit women’s choices.

3. *Public health workers asked the women to come to the nutrition camp under false pretenses. Contraceptive services in Kilinochchi target women and leave men out of the equation.*

Dr. Karthikayan told the fact-finding team that the MOH designed the clinic to collect nutrition information from this underserved population. According to Dr. Karthikayan, nurses and doctors from across Kilinochchi only discovered the unmet need for contraception “on accident” after speaking to women at the clinic.

However, all of the women interviewed for this report – even women who are happy to have the implant – told the fact-finding team that the clinic was clearly designed as a contraception clinic. The nurses discussed contraception with all women and would not allow women to leave unless they signed a letter stating that they wanted more children. Interviewee 2's husband told the team that he and his wife are lucky to have the implant, "but bringing her under false pretenses bothers us." Interviewee 6 says that she feels extremely angry with the educated doctors she trusted. She would go for another camp, but she would ask more questions. Dr. Karthikayan told the team that "the MOH needs to find strategic approaches" to ensure that counseling reaches all women. Here, women saw through the strategy and feel duped by the dishonesty. Interviewee 3, an educated woman, says she feels tricked by the doctors and nurses. She also feels guilty for not asking enough questions.

The MOH failed to tell local health officials that they would be inserting the implant. A doctor with implant insertion training happened to be waiting at the Veravil divisional hospital? Although not a single woman mentioned reading material, Dr. Karthikayan told the team that the nurses used flip charts and brochures to provide the women with background information. *Why would nurses from outside these villages bring contraceptive counseling tools to a nutrition clinic?* Health volunteers told many women to go directly to the hospital without stopping at the preschool for the weigh in. Women in these villages want increased access to contraception. However, luring women on false pretenses creates an environment of distrust and limits women's options for honest conversations about contraceptives.

Additionally, the nutrition clinic strategy shows that MOH contraceptive policies place the entire family planning burden on women. Men have been left out of the conversation. Even when women wanted to consult partners, nurses threatened them or forced them to write letters announcing their desire for larger families. Men play an important part in reproduction, but in the State's contraceptive strategy,

they have no role. The Women's Charter clearly states that family planning policies should focus equally on men and women. (Article 13(ii)(b))

4. *The government health workers coerced women into accepting the Jadelle contraceptive implant.*

Women cannot freely accept contraception where government health workers use power or force to guide women's decisions. Coercion manifests itself in diverse ways. For example, an individual's freedom to choose may be limited by psychological pressure applied by medical staff or government officials. Likewise, if doctors and nurses use social norms, false information, and financial circumstances to pressure women, they employ coercive tactics. Here, doctors and nurses used a broad array of coercive strategies to pressure women into accepting the Jadelle implant.

Many women reported that they felt intimidated by the doctors and nurses who came from "outside" their community. Even women who are happy with the implant felt immense pressure throughout the clinic. Interviewee 1 felt that she could not say no to the doctor and even today she feels "guilty" questioning a doctor's authority by asking to have the implant removed. Women outside of the preschool reported that nurses intimidated the women and asked them questions like, "You use the rhythm method? Tell us about it, show us how you use it." Nurses also laughed at women who reported using traditional methods. Nurses took advantage of this power dynamic by emphasizing that a "big important doctor" would be at the clinic for just one day. As a result, many women believed that they had a one-day window to get the implant.

Other nurses used social norms to pressure women. Interviewee 12 reported that the village midwife asked her, "If you get pregnant over forty, won't you be ashamed?" Nurses at the clinic also told Interviewee 5 that old people should not get pregnant. The midwife also told women in Interviewee 12's village that the

implant would prevent pregnancies that result from drunk men raping or abusing women. Another woman told the fact-finding team that local midwives forced some women because, “it is difficult for the nurses to deal with all of us when we get pregnant all the time.”

Appallingly, other nurses and midwives lied to women. In Interviewee 12’s village, the midwife told women that without the implant, their breast milk would dry up and their children would die. Nurses told women that women who did not accept the implant had to write a letter to officials in order to declare their desire for another baby. Additionally, nurses told many women that they would have to pay 10,000 LKR to have the implant removed. The midwife told Interviewee 13, “if you have the loop and you want to remove it, there is no problem, but with this, you have to pay.” Interviewee 14 plans to remove the implant in two years, but she is afraid she will have to pay. Interviewee 1 also believes she will have to pay for removal.

In this coercive context, free and informed consent is impossible. In General Recommendation 14, the Committee on Economic, Social, and Cultural Rights clarified that the right to health includes the freedom from “non-consensual medical treatment and experimentation.” Under the International Conference on Population and Development (ICPD), Sri Lanka has guaranteed women the right to make reproductive choices in an environment free of discrimination, coercion, and violence. Moreover, the fundamental rights of liberty and bodily integrity guarantee every individual the right to make autonomous health care decisions, including decisions pertaining to sexual and reproductive health. In violation of these rights, women here experienced pressure, intimidation, and dishonesty amounting to coercion.

5. *Government health workers did not provide adequate contraceptive counseling. Women did not give full and informed consent.*

Bayer, the manufacturer of Jadelle, provides thorough instructions for counseling women who may want the implant. The Jadelle training manual for family planning assumes that medical professionals have outlined all information about benefits and limitations of other available contraception choices prior to the insertion of the implant. Clearly explaining the full range of available contraception allows women to arrive at a free and informed decision. Counseling prepares women for any side effects they may develop.

Under international law, counseling constitutes an essential component of informed consent. Informed consent demands that any person who may undergo a medical procedure has information on the risks, benefits, alternatives, and characteristics of a procedure. This information should be tailored to each individual patient's education level, personal circumstances, and medical history. Accordingly, informed consent demands an in depth one-on-one conversation. Proof of this conversation should be recorded and documented.

The interviews in this report clearly show that nurses and doctors failed to conduct adequate counseling or to obtain informed consent. Women could not name potential adverse events, describe the insertion operation or *even name the product in their arms*. For example, Interviewee 1 only understood that nurses sent her to the hospital for some contraceptive, but did not know what and she felt uneasy because she had not spoken to her husband. When the doctor asked her if she wanted five or seven years of protection, she did not understand the question. After receiving the implant, Interviewee 3 waited to tell her husband because she did not have enough information about the implant and "felt guilty." Interviewee 3 wishes she knew more and that, as an educated person, she had asked more questions. Interviewee 13 said that she was forced to do this and was unaware that she could remove the implant. Interviewee 5 told the fact-finding team, "contraceptives are good, but people there should have told the women about it and talked to them. Many women told me that they were inserting the loop in women's arms."

Limited counseling amounted to vague, incomplete or untrue statements. A nurse told Interviewee 14 that she would get a stick that would last for five years. When Interviewee 13 went to the hospital, women were asking whether the implant would make them sick. The nurses said yes, if you get sick, come here and we will treat you, but we will not remove it just because you feel sick.” The nurses and doctors did not have in depth conversations about potential adverse events or side effects. Although Jadelle impacts most women’s periods in some way, many women who had missing periods, spotting or irregular periods told the fact-finding team that they were afraid of what that could mean. One woman told the fact-finding team that her missing periods might mean that she has a tumor.

The following table assesses the Kilinochchi MOH’s compliance with the Jadelle counseling requirements.

Table 4: Assessment of Compliance with Jadelle Counseling Requirements

Jadelle Counseling Obligations:	Whether performed in Umaiyaipuram, Malaiyalapuram , Keranchi, Veravil, and Valaipaddu:
Obtain basic information (name, age, address, etc.)	Yes
Ask client about their reproductive goals	Very Limited
Discuss the need for protection against STD/GTI/HIV/AIDS	No
Ask her if she wants to space or limit births	Limited
Discuss clients needs, concerns and fears while exploring attitudes and cultural or religious beliefs that favor or eliminate certain methods	No
Help client choose an appropriate method	No

After choosing Jadelle:

Make sure there is no medical condition that would be a	Very limited
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problem or require more frequent follow-ups	
Discuss benefits of Jadelle: effective, easy to use continuous protection up to 5 years, convenient, comfortable and reversible	Limited
Explain Jadelle does not protect against GTIs/STDs/HBV or HIV/AIDS	No
Explain common adverse effects, especially changes in the menstrual bleeding pattern, and be sure they are understood fully	Very limited
Describe insertion and removal procedures and what the woman should expect afterwards	Very limited

Procedure/examination area

Review client assessment data to determine if client is an appropriate candidate for the implants	No
Give post-insertion counseling, including how to care for the insertion site	No
What to do if she experiences adverse effects with special emphasis on menstrual bleeding	No
Provide information on warning signs for medical problems and the need to return to the clinic should any occur	No
Assure the client she can return to the same clinic at any time to receive advice and medical attention and, if desired, to have the rods removed	No
Tell the client where she should go to have the rods removed	No
Have the client repeat all instructions back to you	No
Answer any remaining client questions	No
Check client satisfaction	No
Inquire about problems and adverse effects	Limited
Reassure client that rods can be removed at anytime	No
Review warning signs that indicate the need to return to the clinic	No
Repeat instructions regarding need for removal and replacement (if desired) with a new set after five years	No

Women did not have time to think about whether the implant suited their current reproductive goals. Women could not even discuss the implant with their husbands. This vulnerable population may require more in depth counseling to ensure free choice. Although counseling families in these villages may be time consuming, it is the only way

to ensure a woman's fundamental right to informed consent and bodily integrity. Moreover, the Jadelle training manual states, "counseling may appear to be time-consuming, [but] it is cost effective and saves time in the long run. For example, it has been shown that women who receive counseling are more likely to continue using LNG implants and have fewer return visits."

Women did not receive written information about the implant in Tamil or English. The MOH in Kilinochchi provided the team with the implant brochure and mentioned that the Veravil divisional hospital had one brochure for women to read and bring back. Not a single woman the fact-finding team spoke with mentioned a brochure. Jadelle also has a brochure available through the Family Bureau. This brochure is in English. *Again, not a single woman received or mentioned the Jadelle brochure.*

Moreover, the nurses and doctors did not provide tailored counseling to young mothers. Dr. Karthikayan told the team that the age of the women ranged from thirty-five to forty. *However, the fact-finding team interviewed women in their early twenties and even teens who either had the implant or felt pressured to have it.* Unlike older women the team interviewed, these women did not express familiarity with a wide range of contraception. These young women simply do not have the experience to make contraceptive choices without specialized, in-depth counseling.

Nurses and midwives also pressured young rape survivors to accept Jadelle. The nurses did not provide special counseling for these girls or their families. Instead, they callously pushed the implant as a protection against "the same thing happening next time." Instead of addressing the physical, psychological, legal, and medical needs of these girls, public health workers pushed the implant as a means of preventing an outcome of rape (not rape or violence itself). Interviewee 10's mother is afraid that people in the village will know her daughter has the implant and rape her. Interviewee 9's parents see the pressure from the midwives and nurses as added suffering and trauma.

Many women told the fact-finding team that they did not feel comfortable challenging nurses or doctors. Dr. Karthikayan confirmed this belief and said that in this culture, people will not question a doctor's authority. In this context, women must actively be encouraged to ask questions and be given time and information to make decisions regarding contraception.

Counseling is an essential component of informed consent. Simply because a woman says "yes" to a procedure does not mean that she has provided informed consent, particularly if her assent is given without vital information about the procedure or under pressure from doctors and nurses. Nonconsensual medical procedures constitute violations of the right to bodily integrity and the right to be free from cruel, inhuman, and degrading treatment.

At the same time, counseling is an essential component for guaranteeing women's reproductive health and autonomy. In its concluding observations on Sri Lanka (2011) the CEDAW Committee found,¹²

36. While the Committee acknowledges the achievements of the State party in the area of maternal healthcare, it is concerned about the limited knowledge of reproductive health and the low rate of use of contraceptives, the high level of teenage pregnancies especially in less developed and conflict-affected areas, as well as the low accessibility to family planning and the increase in prevalence of HIV/AIDS infection among women.

37. Within framework of CEDAW general recommendation Interviewee 24 the Committee urges:

(a): Ensure that family planning and reproductive health education are widely promoted, in particular for internally displaced women and girls as well as women

¹² CEDAW Committee, *Concluding Observations: Sri Lanka*, U.N. Doc. CEDAW/C/LKA/CO/7 (2011), available at <http://daccess-dds.ny.un.org/doc/UNDOC/GEN/G11/419/41/PDF/G1141941.pdf?OpenElement>

working in less developed and conflict-affected areas, with special attention to the prevention of early pregnancies of girls and the control of sexually transmitted diseases and HIV/AIDS;

Sri Lanka has an obligation to close the knowledge gap on reproductive health, to ensure that all women have access to counseling services, and to guarantee every woman's right to free full and informed consent. Unfortunately, it appears that the State is unwilling or unable to ensure these fundamental rights.

Women and men have equal rights to dignity, respect, and bodily integrity. To ensure equality, the GoSL has an obligation to accommodate acknowledge these differences and to ensure that women have access to the primary health care, contraceptive services, and necessary information to protect their health and dignity. The United Nations Special Rapporteur on Violence Against Women has stated, "[T]he fundamental dignity of women as human beings requires that they should not simply be regarded as child bearers and rearers but as complete individuals who are entitled to rule their own lives. The inability to control the very functions that differentiate women biologically from men is in itself a violation of human rights."

The GoSL clearly relegates women to their "natural" or "biological" role as mothers when public health policies target women because of their ability to reproduce and promote contraceptives as a strategy for limiting evidence of rape.

6. *Government health workers failed to conduct adequate medical pre-screening and to provide post-implant care instructions.*

All operations and drugs require thorough screenings and post-surgical care. Jadelle's product information states that the implant is for healthy women who do not wish to get pregnant. Here, many women who received the implant suffer from malnutrition, weigh less than thirty-five kilograms, and have never had a full gynecological exam. Without adequate access to basic primary care, many of the women will not know if

they suffer from illnesses that could make Jadelle dangerous including “active thrombophlebitis, genital bleeding, acute liver disease, malignant liver tumor, known or suspected breast cancer or other hormone dependent cancer, or if pregnant.”¹³

The Jadelle training manual outlines specific instructions for providers:

“If all the conditions mentioned below are negative the client may be eligible for insertion, if any of the conditions are positive the client will need further counseling prior to insertion. It is also important for the health worker asking these questions to take into account any social or religious factors that may influence how the women may respond.”

The table below compares the pre-insertion instructions with the tests and counseling conducted by the MOH staff.

Table 5: Compliance with Pre-insertion instructions

Medical Condition	Testing?
Pregnancy (known or suspected)	Limited testing done
Urine test -	Limited
Breast tenderness -	No
Pelvic test -	No
Using reliable contraceptive method -	Limited
Is within first 7 days after start of menses	Limited
Within 3 weeks post-partum (non bf) -	Yes
Within 7 days post abortion -	No
Fully bf less than 6m and no bleeding -	Yes
Breastfeeding a baby less than 6 weeks old	Yes
Unexplained vaginal bleeding (i.e., between menses or after intercourse);	No
Jaundice (abnormal yellow skin or eyes)	No
Severe headaches or blurred vision	No
Breast cancer or suspicious (firm, non-	No

¹³ From the Jadelle Patient for New Zealand (Annex II).

tender or fixed) lump in the breast	
Current venous thrombosis or pulmonary embolism	Limited
Taking drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampin)	No
Diabetes	Limited

Failure to adequately conduct all pre-insertion tests jeopardized the health of these women. Moreover, failure to provide the women with after-surgery instructions – including directions for severe adverse reactions – represents a violation of the Jadelle protocol and endangers women’s wellbeing.

Women could not even name adverse events or side effects. The Jadelle product information states that the implant site should be dry for two to three days in order to prevent infection. None of the women knew this information. In fact, the MOH stated that some women in the district have removed the implant after getting infections at the insertion site. The women did not know when to contact a doctor. Regrettably, many of the women had blank or illegible contact information on the small card they received. Women did not know to immediately remove the implant if they become pregnant, that future medication may interfere with the implant or that irregular periods are a normal impact of using the implant.

Moreover, women did not receive accurate information about removal. Interviewee 1 told the team that she wants to remove the implant, “but the medicine would have spread, so what’s the point?” Nurses told Interviewee 11 and Interviewee 15 that they could not remove the implant for five years. Interviewee 13 reported that a nurse told several women that they could not remove the implant for five years because it is so expensive. Interviewee 9 cried in front of the fact-finding team and said that she was unsure of how to remove the implant. Other women thought they had to pay for removal. The Jadelle training manual obligates providers to have pre- and post-insertion conversations about removal. *Here, the public health workers clearly failed to honestly discuss removal.*

The MOH follow-up visits to women in some villages reassured the women, but without access to primary care, subsequent follow-up visits, meaningful conversations about the implant or a full understanding of removal, these visits do not constitute adequate post insertion care.

7. *Public health employees failed to provide information to women who underwent the implant insertion operation.*

In New Zealand, women who accept Jadelle receive a sixteen-page booklet on the implant. This information comes only after a doctor has conducted in-depth counseling, the woman has undergone a medical screening to determine eligibility, and the doctor has performed the insertion. Here, the women received a business card with the date of insertion, the date of removal, and spaces for a doctor or nurse to fill in which arm has the implant, and who to contact with questions. *Moreover, the card is in English, a language none of the women speak or read.*

Doctors and nurses left many cards blank or incomplete. Other cards are completely illegible. The women themselves do not even understand why they have the cards. The cards do not have information about the implant, removal, medical conditions that make the implant dangerous, side effects, breast feeding, when to contact a doctor or when to get a follow-up visit.

The Jadelle information booklet for women in New Zealand also assumes that women will have access to the product insert, or the drug information the manufacturer includes with the drug. Jadelle in Sri Lanka does have a product insert, but Dr. Karthikayan told the fact-finding team that this information is only for doctors. The women have a right to know basic information about the implant. *Why do women in developed countries receive a 16-page booklet, while vulnerable populations without access to primary care receive zero post-insertion information?*

Universally, women cannot name the contraceptive in their arms.

Likewise, the blood pressure record card that MOH doctors provided to women who received follow up home visits contains zero information about the Jadelle implant.

Patients have a right to information about drugs take and procedures they undergo. Without information on this drug, women cannot address adverse events, freely remove the implant, understand potentially conflicting medications, take appropriate steps in the case of pregnancy or provide information to their husbands or future medical care providers.

8. *Women feel unsafe asking doctors questions, speaking to human rights activists, and government employees have told their subordinates, including field health workers to remain silent on this issue.*

The RHA has been told to remain silent on this issue. The MOH in Colombo prohibited Dr. Karthikayan from speaking with journalists. The team could not find any nurses ready to speak about this clinic. *Why have health workers been prohibited from speaking?* Generally, women feel uncomfortable questioning doctors or nurses. Here, they feel they have been cheated, duped, and lied to, but they do not have a complaint mechanism to demand explanations or to enforce their rights.

Sadly, many women told the team that they fear retribution for speaking out. Army personnel have been following this issue. They called a local doctor ten times and have spoken to a village health worker about the implant clinic. Given this community's history, contact with the military fuels fear. Interviewee 3 told the team that people from her village would be refused treatment at the Kilinochchi Hospital in retaliation for speaking out about the implant clinic. Interviewee 13's husband heard that if she gets sick, no one would help her.

In this context, there is no accountability for doctors and nurses who do not follow basic protocols for informed consent, pre-surgery screening or contraceptive service counseling.

3 Recommendations

To ensure accountability, basic health facilities, and the reproductive rights of women in Umaiyalpuram, Malaiyalapuram, Keranchi, Veravil, and Valaipaddu, TSA recommends:

3.1 To the Government of Sri Lanka

1. Conduct an in depth MOH and civil society investigation on Jadelle implant insertions in the North.
2. Conduct a comprehensive health and reproductive health survey for Kilinochchi District with results made public.
3. Provide information on the implant in Tamil and English. Information should also be available for women who cannot read. Adequate information should be provided at all health centers. Women should be able to take the information home.
4. Appoint adequate midwives, nurses, and doctors in Kilinochchi immediately, as per government schemes and policies
5. For the MOH to develop an easily accessible complaint mechanism for women with questions, comments or concerns regarding their experiences with the public health system.
6. For the MOH to create a mandatory check-list for counseling, pre-insertion counseling, and post-care instructions for each implant insertion.
7. For the MOH to conduct a reproductive rights training for doctors, nurses, and midwives.
8. For the MOH to conduct a reproductive rights training for doctors, nurses, and midwives.
9. Reduce the presence of military personnel in the Northern Province.
10. Provide accurate statistics about militarization to the public.

3.2 To Civil Society

11. Conduct trainings on reproductive health in villages in Kilinochchi District.
12. Conduct a reproductive rights training for doctors, nurses, and midwives.
13. Provide these women with information on removal in a language they understand and hold several village-wide meetings to explain the implant, steps for accountability, the clinic, and alternate forms of contraception.

3.3 To Bayer, the manufacturer

14. Ensure that all doctors and nurses are familiar with the training manual for family planning for counseling, screening, insertion, and post-insertion care.
15. Conduct trainings for doctors and nurses per the Jadelle training manual for family planning.

3.4 To the International Community

16. Conduct a rights-based review of family planning, contraceptive services, and reproductive health projects in Sri Lanka.
17. To review whether funding for Jadelle, an expensive contraceptive, represents a rational public health expenditure.
18. To consult with local community groups and CSOs to ensure that projects and programs are tailored to individual community needs.
19. To urge the GoSL to publicize health indicators from the North and East.
20. To pressure the GoSL to fulfill its international obligations under CEDAW, CRC, and ICESCR.
21. For UNFPA, as funder for this project, to undertake a thorough study on what went wrong in these Kilinochchi villages.

Annex 1: Demographic Data

Annex 2: Jadelle Patient leaflet

Annex 3: Interviews

Annex 4: Jadelle Card- Proof of Implant

Annex 5: Post Insertion Health Record

Annex 6: Photos