

Designing a National Framework for Age-Appropriate Comprehensive Sexual and Reproductive Health Education: Insights from Pakistan and Sri Lanka

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Review Article

Abstract

Introduction: In South Asia, adolescents face various challenges related to sexual and reproductive health education (SRHE) due to insufficient awareness, contributing to an alarming rate of teenage pregnancies. In Sri Lanka and Pakistan, reproductive health-related topics are included in the curriculum; however, they remain fragmented, with an overemphasis on the biological component, while ignoring emotional well-being, consent, contraceptive awareness, and safe relationship protocols, resulting in a high rate of teenage pregnancies. Both countries face cultural and religious taboos that hinder the effective delivery of comprehensive, age-appropriate SRHE. The review aimed to explore how age-appropriate sexual and reproductive health education is currently addressed in Pakistan and Sri Lanka. Second, the review aimed to propose an integrated age-appropriate national framework on SRHE for Sri Lanka and Pakistan, based on the best global practices.

Methods: To conduct this review, a qualitative narrative review approach was adopted. A search was conducted across digital databases (PubMed, ScienceDirect, Google Scholar) and grey literature from UNESCO, UNFPA, WHO, National ministries' websites, and theses. A keyword search using Boolean operators (AND/OR) was conducted from 2015 to 2025. A total of 26 studies (i.e., 15 empirical studies, 7 government reports, 3 theoretical and conceptual literature, and 1 web portal/commentary) were synthesized and included in the review.

Results: The study findings suggest three major gaps in existing SRHE awareness among adolescents in South Asian countries, i.e., Pakistan and Sri Lanka. These include inadequate teacher training on SRHE, community-restricted attitudes towards SRHE advocacy, and the absence of a unified curriculum.

Conclusion: As a future course of action, this review proposed a five-pillar national age-appropriate framework, guided by the UNESCO spiral model, to enhance structured advocacy, teacher preparedness, and culturally sensitive implementation of SRHE awareness.

Key Words: adolescents, South Asia, sexual and reproductive health education (SRHE), life skills-based education (LSBE)

Introduction

Adolescent sexual and reproductive health education (SRHE) is a cornerstone of the global public health agenda as it affects long-term outcomes related to gender equality, well-being, economic productivity, and supporting Sustainable Development Goals, SDG 3 and SDG 5. The World Health Organization and UNESCO advocate for comprehensive age-appropriate SRHE as an evidence-based approach, with age-appropriate curricula that encompass physical, emotional, social, and rights-based aspects of reproductive health to promote informed decision-making and healthy behaviors [1–3]. Although there have been global advancements (i.e., the International Conference on Population and Development (ICPD) (1994) and the Nairobi Summit (ICPD25, 2019), including reducing the fertility rates of adolescents, particularly in low-and middle-income countries (LMICs), where adolescents experience various reproductive health-related issues, such as teenage pregnancies [4,5].

Age-appropriate frameworks are quintessential in promoting sexual and reproductive-health-related awareness, as fragmented programs fail to provide young people with the required skills needed for informed consent in the pursuit of developing healthy relationships while navigating their vulnerabilities [5]. Statistics from a study reveal that in Pakistan, approximately 50% of the births are to women aged below 20 years living in resource-constrained rural areas [6]. Globally, the majority of people aged between 10–24 years are living in LMICs. This burgeoning and rapidly growing stratum (340 million adolescents) is experiencing cultural and societal taboos associated with SRHE, particularly those living in South Asian countries.

Access to information and services related to SRHE is further restricted by stigma and gender inequalities, which increase the risk of teenage pregnancies and gender-based violence [7]. This is especially concerning when adolescents are at a stage of developing physical, cognitive, and emotional capabilities and undergoing robust changes, which are essential for adult life [8]. In LMICs, providing age-appropriate SRHE to adolescents is often hindered by socio-cultural and religious conservatism across Pakistan and Sri Lanka, which creates resistance or hesitation to SRHE initiatives [8–11]. Additionally, these challenges are further compounded by the lack of teacher training programs, which leads to inadequate and biology-focused education that is ill-suited to adolescents' emotional, psychological, and developmental needs.

Pakistan and Sri Lanka are countries with South Asian cultural foundations and religious conservatism, predominantly Islam in Pakistan and Buddhism in Sri Lanka, which stigmatizes open discourse on sexual and reproductive health-related awareness; however, both countries differ in terms of educational infrastructure and the implementation of sexual and reproductive health-related initiatives. In Pakistan, adolescents comprise 23% of the population, with only 38% of girls reporting knowledge of reproductive health; 617,000 adolescent pregnancies are reported annually, 36% of which are unintended, with more than half ending in abortion, amid contraceptive use of 3.5% [12,13]. There is no unified guidance in curricula, which are fragmented and biology-centric, and this is exacerbated by religious objections that portray SRHE as a way to promote immorality, teacher discomfort, and policy inertia [5,14–18]. Thus, the results reveal

that this limited awareness of reproductive health rights and services available is closely tied to community and faith-based norms [16,18,19].

Whereas Sri Lanka reports a high literacy rate (92%) with mandatory primary education, education related to reproductive health topics is fragmented. As the curriculum is widely biology-focused, it prioritizes physiology over consent and adolescents' emotional well-being [17,20]. Although UNFPA supports initiatives, only 59% of young people received school-based sexual and reproductive health education, with low or no contraceptive knowledge, as well as access barriers among unmarried adolescents, persisting faith-driven moral conservatism, and reluctance among teachers [20–22]. Evidence reveals that adolescents do not have satisfactory SRHE (<1% satisfactory). This gap is accelerating among out-of-school youth, as they are more prone to issues such as sexually transmitted diseases, unintended pregnancies, and a lack of knowledge about informed consent in maintaining a healthy relationship [23,24]. Both countries face similar religious-cultural obstacles, teacher education constraints, and the absence of a centralized national education framework, yet Sri Lanka's developed educational foundation offers greater potential for reform than Pakistan's, which has a more constrained policy environment [15,18,25].

To address prevailing concerns related to sociocultural and religious factors (e.g., belief-driven attitudes) towards sexual and reproductive health education remains a critical gap. Approaches that are age-appropriate, socio-culturally sensitive, and advocate for the inclusion of psychological and emotional elements of reproductive and sexual health in adolescents are needed. Studies indicate

that existing initiatives are fragmented and lack uniform reproductive health education across the country that can be adapted to local community needs; therefore, upscaling of these initiatives remains a challenge [15,19,26]. This void calls for an integrated, inclusive, age-appropriate, evidence-based model for adolescents to equip them with the knowledge and skills needed to address risks associated with sexual and reproductive health. This narrative review synthesizes evidence from 2018-2025 to map the SRHE landscapes of Pakistan and Sri Lanka and propose a culturally attuned national framework with two objectives. First, to explore how age-appropriate sexual and reproductive health education is currently addressed in Pakistan and Sri Lanka. Second, to propose an integrated national framework for Sri Lanka and Pakistan, based on the best global practices.

Methods

A qualitative narrative review approach was adopted for this study, which allows the integration of heterogeneous evidence from the SRHE framework within the existing education systems of Pakistan and Sri Lanka from diverse literature, including peer-reviewed articles, policy documents, and theses (grey literature). This approach enabled us to synthesize evidence interpretively on evolving challenges related to implementation (including teacher reluctance and faith-driven cultural norms) and develop a nuanced contextual understanding across countries, while focusing on behavioral and policy barriers.

Search Strategy

Literature was sourced from digital databases (PubMed, ScienceDirect, Google Scholar) and grey literature from

Table 1. Summary of Search Strategy and Study Selection Criteria

Stage /Description	Details
Search sources	PubMed, ScienceDirect, Google Scholar; grey literature from UNESCO, UNFPA, WHO, national ministries' websites, and academic theses.
Search timeframe	2015 to 2025.
Keywords used	Reproductive health education, age-appropriate reproductive health education, sexuality education, school curriculum, adolescent reproductive health policy, adolescents, youth (10-24 years), Pakistan, Sri Lanka; combined using AND/OR operators.
Inclusion criteria	Peer-reviewed studies, policy briefs, reports, theses, and government documents focusing on adolescents and youth aged 10-24 years and addressing reproductive health education or related educational policies in Pakistan and Sri Lanka.
Exclusion criteria	Publications before 2015; purely clinical interventions without educational or policy relevance; studies not focused on reproductive and sexual health education and adolescents.
Total included studies (n = 26)	Pakistan-focused: 13; Sri Lanka-focused: 9; Cross-country/global framework sources: 4.

UNESCO, UNFPA, WHO, national ministries' websites, and theses. A keyword search using Boolean operators (AND/OR) was conducted from 2015 to 2025. Keywords included "reproductive health education", "age-appropriate reproductive and sexual education in Pakistan OR/AND Sri Lanka", OR/AND "South Asia," "adolescents," "youth." As shown in Table 1, key sources included data from UNFPA, UNESCO, WHO, the national youth health survey of Sri Lanka, the Nairobi Summit on ICPD25, and Pakistan Demographic Surveys and published reports.

The inclusion criteria encompassed published peer-reviewed policy briefs, theses, reports, and government reports on adolescent/youth sexual and reproductive health education in Pakistan and Sri Lanka, broadly across South Asia/low-middle-income countries (LMICs). Exclusion criteria were defined as literature published before 2015 and clinical interventions on adolescents' reproductive or sexual education awareness. Following

these inclusion and exclusion criteria, a total of 26 studies (i.e., 15 empirical studies, 7 government reports, 3 theoretical and conceptual literature, and 1 web portal/commentary) were synthesized and included in the review. Since the focus was on two countries, i.e., Pakistan and Sri Lanka, 13 studies were included from the Pakistan literature and 09 studies were included from the Sri Lankan literature, whereas 04 provided a global comparative framework on adolescent reproductive health education and the five-pillar framework.

Evidence Appraisal Criteria

For quality appraisal of the included literature, the mixed methods appraisal tool (MMAT) edited version (2015) was adapted for this study, and diverse formats were assessed, including quantitative studies, qualitative studies (grey literature/thesis), narrative and systematic reviews, mixed-method studies, policy reports, blogs, and press releases. Emphasis was placed on

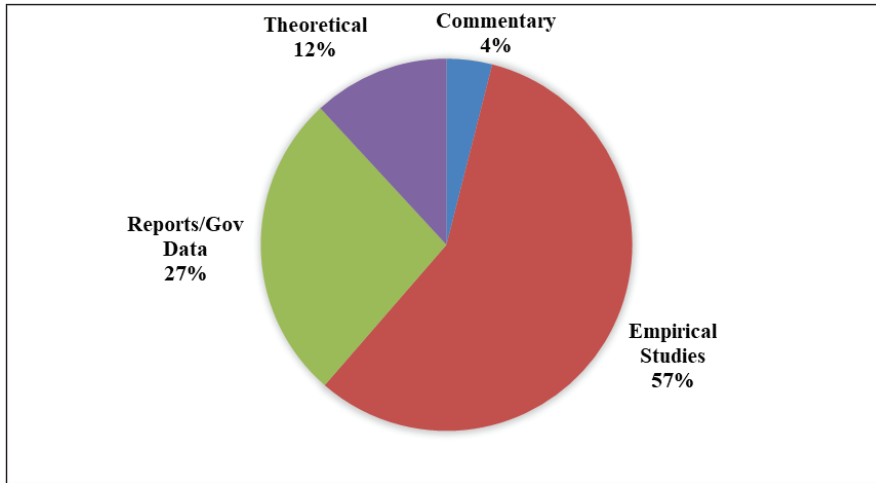


Figure 1. Distribution of Evidence Types included in the Review.

relevance to reproductive health-related awareness in curricula, methodological relevance (e.g., the target population aged from 10 to 24 years), included reports, repositories, national policies, and credibility of sources (e.g., government initiatives and policy reports of ministries or other government bodies). UNFPA, UNESCO, and WHO policy briefs were included as high-scoring items because of their actionable policy evidence; data from unreliable sources, such as commentaries and LinkedIn post analyses, were discarded to ensure evidential balance.

Data Extraction and Synthesis Process

Data extraction was performed manually using a spreadsheet matrix, capturing the study elements (delivery and content relevance), barriers (cultural relevance), and outcomes (knowledge gaps) regarding reproductive health education, drawn from selected databases and appended reports. Similarities (e.g., UNFPA- and UNESCO-backed curriculum patterns) and challenges (e.g., lack of age-appropriate reproductive health education in educational institutions,

belief-driven religious responses) were identified through cross-country comparisons and iterative pattern analysis from both countries. The study results were synthesized narratively, without using any software, weaving themes into policy-relevant insights from reports published in recent years to evaluate sexuality education among youth in educational institutes through inclusive curricula while balancing a biological focus with emotional and psychological factors associated with reproductive health.

Results

Existing curricula in Pakistan and Sri Lanka are markedly fragmented and largely prioritize biological aspects of reproductive health education, overlooking psychological, emotional, and rights-based components, which are crucial for comprehensive sexual and reproductive health-related education (SRHE). In Pakistan, SRHE content exists under the umbrella of life skills-based education (LSBE), though it is provided in a fragmented manner [8,27]. Young people constitute 23% of the total

Table 2. Adolescent SRH Crisis Indicators: Pakistan vs Sri Lanka (2023-2025)

Country	Unintended Pregnancies	Teenage Pregnancies
Pakistan	47% (6 million total, 2023)	41 births per 1,000 girls aged 15–19 (2023)
Sri Lanka	33% (approximately 120,000 of 360,000, 2025)	3.8% of registered pregnancies (2023)

Note: Pakistan data were sourced from [29,30], and Sri Lanka data were sourced from [26,31].

population in Pakistan, and this group faces numerous SRHE related challenges [6], such as early marriage, limited knowledge about contraceptives, unintended pregnancies, non-medical or self-administered abortion practices, and insufficient knowledge about hormonal and developmental changes in the body during puberty [16,28,29]. The LSBE curriculum includes content and guidance on SRHE-related concerns broadly, such as gender norms, reproductive health, and HIV/AIDS knowledge; however, the focus remains largely biologically, and implementation of this curriculum remains limited due to community resistance and limited or negligible government support [14,19].

Similarly, in the Sri Lankan curriculum, initiatives have been undertaken with support from UNFPA to raise awareness of reproductive and sexual health, with a primary focus on anatomy, hygiene, and menstruation. Although literacy on early pregnancies, safe sexual relationships, contraceptive use, and consent before sexual activity remains neglected, this is compounded by teacher hesitance and stigma attached to speaking about sexual health in educational settings where the system is mainly religion-based and belief-driven [8,16,20,26,29]. Thereby, these challenges and imbalances contribute to knowledge gaps, demonstrating that only 59% of the youth have access to school-based sexual and reproductive health education, with less than 1% reporting satisfactory awareness of this issue [21,23].

The statistical landscape presented in Table 2 illustrates that 47% of pregnancies are unintended in Pakistan, and 41 births per 1,000 Pakistani girls aged 15-19 years [29,30]. Whereas in Sri Lanka, 33% of pregnancies (approximately 120,000 annually) are reported as unintended amid cultural silences [26]. Moreover, in Pakistan, approximately 3.8 million abortions are reported annually [29], while teenage pregnancies account for 10-13% of maternal deaths. Even though Sri Lanka has seen a decline in teenage pregnancies from 6.5% in 2009 to 3.8% in 2023, reforms to existing curricula are needed to embed SRHE for adolescents.

These pathways must be age-appropriate to address cultural and individual needs. Some initiatives have been taken in the Pakistani province of Sindh as part of a UNFPA-supported project named Aahung, which integrates SRHE partially into existing LSBE content, where “puberty changes” are taught to Grade 6, and healthy relationship norms are taught to Grade 8; however, consent in sexual relationships remains diluted due to religious and cultural resistance [8,14,27,32]. In Sri Lanka, despite UNFPA support and implementation assistance, topics related to contraception and safe sex have been omitted amid backlash from parents and religious leaders. A textbook named “Hathe Ape Potha” teaches Grade 7 students about menstruation and hygiene-related issues [26,31].

Across included studies, adolescents and young adults have limited or no awareness of reproductive health education, and their rights and sources of support are often unclear or unavailable, and they mainly rely on information acquired from social media or websites. Since SRHE awareness is stigmatized, this age group heavily relies on alternative sources such as websites, peer groups, social media, outside formal educational institutions, and the information obtained is often not age-appropriate [23,24].

Teacher Preparedness and Training Gaps

Instructors in educational institutions often lack adequate knowledge and training on reproductive health-related issues, resulting in hesitation and discomfort when educating adolescents about the psychological, emotional, and physiological aspects of reproductive health. [5,14]. In Pakistan, educators face community pressures when addressing reproductive and sexual health-related issues, while teachers from Sri Lankan institutions grapple with societal taboos and insufficient knowledge of psychological and emotional well-being literacy [5,11,26]. Adolescents are considered to be the foundational group within the population, as individuals shape their beliefs about reproductive and sexual health [8] during this stage of development, including their emerging identities. Therefore, adolescence is considered a critical developmental stage for making reproductive health-related awareness effective.

The scarcity of professional teacher training programmes, compounded by cultural taboos, limited pedagogical tools, and conventional educational norms, limits the scalability of such educational initiatives [8,10].

An exemplary programme was carried out in Indonesia, known as “World Starts with Me” (WSWM), in which teachers were trained in rights-based delivery and workshops were conducted for parents, resulting in visible changes in attitudes and knowledge regarding sexuality related topics [33,34]. Integrating these training programmes with local government and NGO partnerships can equip teachers and policymakers to address the emotional and psychological dimensions of SRHR and increase sexual and reproductive health awareness among adolescents in Pakistan and Sri Lanka.

Cultural, Religious, and Community Barriers

To develop a comprehensive sexual and reproductive health-related education (SRHE) discourse, religious conservatism and cultural taboos create the most significant obstacles, causing parental resistance, shame, and misinformation that hinder outreach efforts [10,13,19]. In Pakistan, faith-based norms surrounding SRHE portray it as promoting immorality and immodesty in society [14]. Despite the high literacy rate reported in Sri Lanka, there are socio-cultural and religion-based resistances to promoting reproductive health-related education among adolescents [11,20]. These challenges are more pronounced among adolescents outside formal educational institutions, who often face stigma and have limited or no awareness of reproductive health, their rights, and available support services [23] and may therefore rely on social media and websites for information that is often not age-appropriate.

Takeaways from various recently implemented programmes highlight that parental and educator acceptance of SRHE education can be increased through the

inclusion of community religious leaders and positive engagement with social media. Approaches such as WSWM's Asian programme engage the community through awareness workshops, increase acceptance and adaptability, and create alignment with local values. Such steps can help ensure the long-term success of SRHE frameworks in both countries.

Discussion

The review synthesis suggests that adolescents from Pakistan and Sri Lanka are left vulnerable due to gaps in SRHE awareness, as the knowledge they have been equipped with in conventional institutions is biologically narrow and inconsistently connected to their psychological realities [13,17,26,31]. These challenges leave adolescents vulnerable to experimenting and seeking information from inappropriate sources, rather than preparing them for real-world risks with adequate knowledge about SRHE. Thus, there is a need to develop an integrated SRHE framework for adolescents that is age-appropriate and emphasizes the relationship skills they require for the near future, including an understanding of consent in relationships (i.e., 'yes means yes' and 'no means no' for any sexual or non-sexual activities), the ability to set personal boundaries within relationships, and the capacity to navigate peer pressure. These considerations can bridge these gaps, prioritizing psychosocial competencies over a biological emphasis, as a biology-centric SRHE curriculum may fail to influence adolescents' and young adults' behaviour, and reduce adverse outcomes unless paired with rights-based, age-appropriate, and skill-focused curricula [3,5,35].

Insights from both countries further highlight the challenges associated with

the full-scale implementation of SRHE curricula. In Pakistan, many initiatives have stalled at the initial stages because of community resistance and a lack of state support mechanisms, as seen with the LSBE project. Similarly, in Sri Lanka, despite UNFPA backing, faith-driven moral conservatism and educators' hesitancy to provide SRHE-related information led to issues such as resistance to contraceptives and safe-sex practices. This policy inertia leaves adolescents from both countries facing the same concerning outcomes, knowledge gaps and heavy reliance on informal and potentially unsafe online sources, such as social media platforms and websites, which often provide inaccurate or unrealistic information.

Educator Preparedness as a Bottleneck

Across studies, educator readiness emerges as a critical bottleneck. Reportedly, in formal settings, teachers report inadequate knowledge and training, and, in most cases, fear of community backlash when addressing psychological, physiological, and emotional aspects of SRHE-related education [5,11,14,26]. This reluctance reinforces the silence around the significance of consent, safe relationship guidance, and digital safety. The Indonesian WSWM project reveals that training educators alone is insufficient; in fact, such training must also engage parents, caregivers, and institutions through incentive-based initiatives such as certifications and short-term training workshops to overcome stigma and ensure effective implementation of SRHE [33,34,36]. Instead of relying on ad hoc workshops, pre-service and in-service training in Pakistan and Sri Lanka should be supported by state-driven policies [14,18].

Sociocultural and Faith-based Constraints

The review findings suggest that the main structural barriers to SRHE outreach efforts are cultural taboos coupled with religious conservatism, which contribute to parental resistance, misinformation, and shame surrounding SRHE advocacy [10,20]. Despite increasing literacy rates in both countries, evidence suggests that faith-driven norms frame SRHE as “immoral knowledge” that should be excluded from adolescents’ curricula [11,14,17]. In such conservative settings, initiatives that align with community norms while protecting dignity have successfully reduced resistance to SRHE education [5,11]. Partnerships with religious scholars and community leaders may therefore play an important role in repositioning SRHE awareness as compatible with the country’s moral and religious teachings, while supporting the co-development and integration of SRHE curricula into existing education systems [5,10,14]. Whereas, in Sri Lanka, engaging faith leaders and developing safe spaces for parent-teacher open forums for dialogue can create safe boundaries for discussion around SRHE in educational settings, while such inter-group interactions can help preserve core competencies related to safety and consent for adolescents and young people [11,26,37].

Why a National Framework Is Needed?

There is a dire need for a national SRHE framework that addresses the systematic failures associated with fragmented curricula, inadequately trained teachers, and unaddressed resistance, which have resulted in inconsistent quality and stalled progress across initiatives in this area [14,26]. Projects in Sri Lanka and Pakistan,

supported by UNFPA, demonstrate potential, however, they remain fragmented and lack coordination at the national level [31]. As the needs of each age group differ, particularly during adolescence, an age-appropriate, unified SRHE framework with mandatory training for teachers and parents is crucial. Developing a digital system to collect and monitor data on early and unintended pregnancies among adolescents [38] can also provide real-time evidence to inform adaptations to existing systems and strengthen the promotion of SRHE.

To support adolescents’ holistic development in reproductive and sexual health awareness, the centralized framework should incorporate digital safety, rural equity, cultural and faith considerations, and sensitivity to social norms in such discussions. Practical examples can be drawn from the WSWM-Malaysian project and guidance available from UNESCO and WHO [2,3,34]. Drawing on these examples and guidance, this narrative review synthesized existing empirical evidence, structural information, and reports to translate the evidence into an equitable and culturally responsive SRHE framework based on five-pillars for Sri Lanka and Pakistan.

Way Forward: Proposed National Framework

By synthesizing existing literature, the narrative review proposed a national framework outlining a practical pathway to introduce a culturally sensitive and age-appropriate SRHE approach for adolescents and young people aged 10 to 24 years in Sri Lanka and Pakistan. While rooted in the UNESCO spiral curriculum, which promotes the notion of introducing

topics to adolescents gradually and as they become emotionally mature, considering their psychological readiness for sexuality related information [26]. The proposed SRHE framework consists of three core principles:

- Rights-based learning
- Cultural sensitivity
- Community trust building

These core principles focus on the early involvement of the community, parents, and religious representatives in both countries (Pakistan and Sri Lanka). Structured content by age group is considered the first pillar of this five-pillar framework, which follows a gradual, systematic progression to reproductive-health education based on Aahung's LSBE model [8,34,36]. This

model represents the UNESCO spiral curriculum guidelines, where revisiting key topics [3] each year increases depth as per Bruner's spiral learning model [39], and explains how younger adults (aged 10 to 12 years) learn basic body awareness and safety. Adolescents aged 13-15 are being introduced to relationships, consent, and mutual respect, whereas young people aged 16-24 years are guided on digital safety, online bullying, and safe social media use, and how they can protect themselves in virtual environments. The second pillar of this framework explains how crucial teacher training and certification are for the successful execution and upscaling of sexuality and reproductive health-related education initiatives in Sri Lanka and Pakistan, ensuring that teachers possess adequate knowledge and skills to teach sensitive topics without any stigma

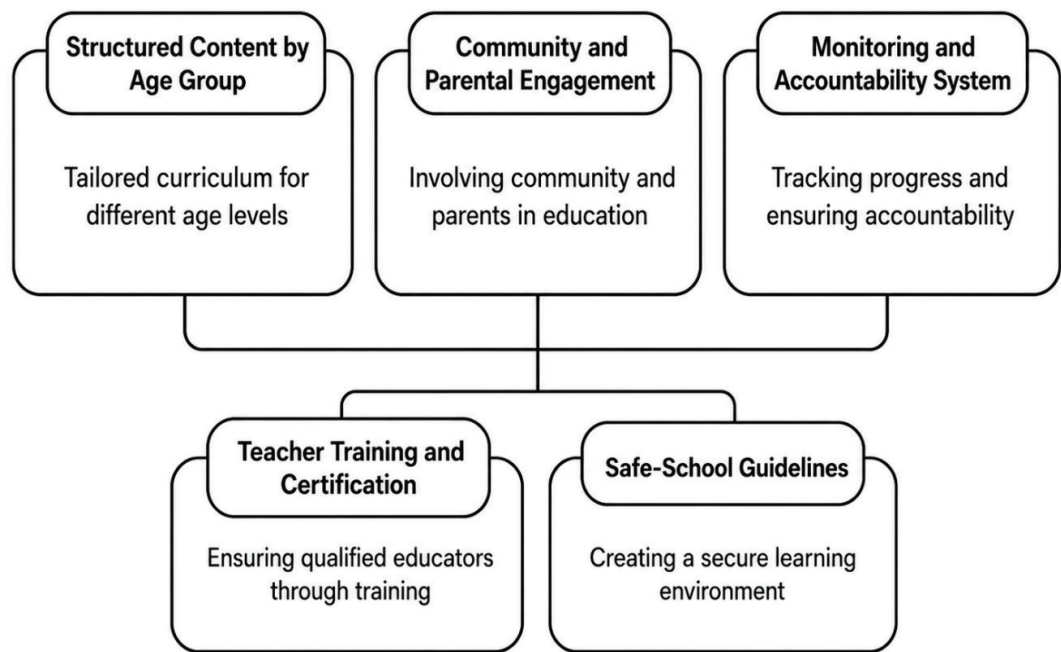


Figure 2. Proposed Five-Pillar Age-appropriate Sexual and Reproductive Health Education (SRHE) National Framework for Adolescents in Sri Lanka and Pakistan.

or predefined thought patterns about sexuality education, as recommended by WHO [2].

Taking into account the community and parental engagement as the third pillar of this proposed SRHE framework. Since attitudes towards sexuality education for children in schools are widely driven by faith and religious conservatism in Sri Lanka and Pakistan, it is suggested that the inclusivity of these religious leaders can bring meaningful change, as demonstrated by the World Starts with Me (WSWM) Asia model [34]. This model has already been successfully implemented in Muslim-majority countries such as Indonesia and Malaysia; therefore, these are practical examples for a Muslim-majority country, Pakistan, where the same model can be executed through culturally tailored participatory workshops, local community leaders, parents, and teachers to improve acceptability towards sexual and reproductive health education among adolescents [33,34,36]. Recently, Aahung has implemented a similar model while engaging in community consultations and culturally appropriate framing in a project titled "Life Skills Based Education" (LSBE), proven to be a successful execution in Muslim-dominant societies like Pakistan [8,16].

The fourth pillar of this SRHE framework is ensuring safe school guidelines for children, explaining the proper methods of how to respond to harassment, gender-based violence, and manipulation through social media or any digital risks. The fifth pillar is the monitoring and accountability of existing projects through student feedback forms, surveys, and building reporting systems while maintaining transparency in educational institutions, and deploying SRHE frameworks to

promote sexual and reproductive health awareness.

Limitations

This narrative review included literature and evidence from Sri Lanka and Pakistan; this country-specific focus limits its generalizability. Studies were synthesized narratively; therefore, the results may be influenced by subjective biases. Limited local empirical evidence captured insufficient lived experiences of adolescents amid digital gender divides, as in Pakistan, where digital accessibility is more pronounced than in Sri Lanka.

Conclusion

This narrative review aimed to synthesize and map the existing evidence available on age-appropriate SRHE in two countries, i.e., Sri Lanka and Pakistan, for adolescents aged 10 to 24 years. Key findings suggested that policy implementation is fragmented in both countries, despite high rates of unintended and teenage pregnancies reported (47% in Pakistan and 33% in Sri Lanka), and a substantial lack of awareness of issues related to reproductive and sexual health. As proposed, the five-pillar sexual and reproductive health education framework is guided by the UNESCO spiral, Bruner's 3-step learning model, findings from The World Starts with Me (WSWM) Asia project, and Rutgers's rights-based initiatives.

The five pillars framework includes structured content by age group, with the first pillar providing gradual learning based on adolescents' developmental stages. The second pillar is teacher training and certification, which ensures that educators are fully equipped to deliver this sensitive knowledge in educational institutions with

skill and confidence, while incorporating community and parental engagement. Trust and acceptance from community leaders, teachers, and parents form the third pillar, which advocates for safe-school guidelines (addressing harassment, GBV, and digital safety). The fourth pillar addresses gender-based violence, risks associated with digital safety, and harassment. The fifth pillar of the SRHE framework supports a continuous monitoring and accountability system through surveys and transparent feedback mechanisms.

These pillars address the voids, offering an SDG-focused framework (SDG 3.7/5.6) for SRHE advancements through SAARC coordination in South Asian countries. The findings of this review suggest that countries like Pakistan should prioritize strengthening existing life skills-based education initiatives through government ownership and policy reforms while promoting public-private collaborations. Whereas Sri Lanka should focus on expanding its existing school-based curriculum initiatives, and both countries should expand the existing efforts into a comprehensive, centralized national-level curriculum, beyond biology, focused on addressing adolescents' emotional and psychological needs. The proposed five-pillar framework can provide a practical and culturally sensitive roadmap to strengthen adolescents' reproductive health education in both countries, as well as potentially across South Asia.

Ethical Approval

Ethical approval was not required for this study because it was a narrative review based exclusively on previously published literature and publicly available secondary data. The study did not involve

human participants, collection of primary data, clinical interventions, or access to personally identifiable information.

Author Contribution

Sana Naz conceived the study, conducted the literature search, and completed the manuscript. Dr. Malathie Dissanayake provided academic supervision. Both authors read and approved the final manuscript.

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Conflict of Interests

The authors declared no conflict of interests in publishing this study.

Data Availability Statement

Since this study has analyzed existing studies on sexual and reproductive health education, all included data and sources are publicly available.

Statement on the Use of AI

For language editing, refinement, and sentence structure alignment, Grammarly was used in this study.

Disclaimer

The views expressed in this paper are those of the authors and do not reflect the views of their affiliated institutions.

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