Adolescent and Youth Reproductive Health in

Sri Lanka

Status, Issues, Policies, and Programs

POLICY

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ADOLESCENT REPRODUCTIVE HEALTH IN SRI LANKA

Status, Policies, Programs, and Issues

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POLICY Project

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CSP	Counseling service points
DHS	Demographic and health survey
EC	European Community
FHB	Family Health Bureau
FPASL	Family Planning Association of Sri Lanka
HEB	Health Education Board
HIV	Human immuno-deficiency virus
IEC	Information, education, and communication
NGO	Nongovernmental organization
NIE	National Institute of Education
NYSC	National Youth Service Council
PHM	Public health midwife
RHI	Reproductive Health Initiative
SDPs	Service delivery points
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 INTRODUCTION

The purpose of this report is to highlight the reproductive health status of adolescents in Sri Lanka. This is part of a series of assessments in 13 countries in Asia and the Near East.[1] The report begins with a description of the social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to adolescent reproductive health (ARH) and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies barriers to ARH and ends with recommendations for action to improve ARH in Sri Lanka.

It is universally accepted that adolescence is a period of sexual maturity that transforms a child into a biologically mature adult capable of sexual reproduction. Adolescence has been described as a period of sexual development from the initial appearance of secondary sex characteristics to sexual maturity, psychological development from child to adult identification, and socioeconomic development from dependence to relative independence.[2]

WHO defines adolescents as persons between 10–19 years of age, youth as those between 15–24 years, and young people as those between 10–24 years. Many studies throughout the world have adopted these WHO definitions. Defining adolescence and youth by a particular age range may defy standardization since different terms and age ranges are commonly encountered in the literature. Sociologically or biologically, there is no universally accepted beginning or end of adolescence.

More importantly, reproductive health data for young adolescents (10–14) hardly exist in developing countries, including Sri Lanka. Therefore, the present study, unless otherwise stated specifically, will use data from the 15–24 year-old age group and refer to individuals in that age group as adolescents.

The size and growth of the adolescent population in Sri Lanka are determined by the levels and trends in fertility and infant and childhood mortality. Adolescents (ages 15–24) comprise 19 percent of the Sri Lankan population. It is estimated that the size of the adolescent population will decrease from 3.7 million in 2001 to 3.1 million in 2021 (Figure 1). This decline is attributed primarily to the significant drop in fertility rates since the 1960s.[3]

There are few disparities between young men and women in their educational attainment, although a higher percentage of young women than young men have received 10 or more years of schooling (Figure 2). Almost twice as many young men as young women are employed (Figure 3). Among adolescents, the unemployment rate is higher for females than males.[4]

In 2001, it is expected that females ages 15–24 will contribute about 80,282 live births—about one-quarter of the total live births of all females of reproductive age (Figure 4). Over the next 20 years, live births among women in this age group are expected to decline. Thus in 2021, only 17.4 percent of the total live births are expected to be among women ages 15–24.[5]

[1]The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.
[2] WHO, 1975.
[3] De Silva, 1997a.
[4] Department of Census and Statistics, 2001a.
[5] De Silva, 1997a.

The processes of modernization and globalization will place greater strains on adolescents in the future. While the Sri Lankan government has taken these changes into account in formulating policies for adolescents, they have done so without a consistent definition of adolescence or correct information on the emerging problems. As a result, policymakers have not adequately dealt with the problems affecting adolescents.

Sri Lanka's achievements in the health sector have been impressive. Yet, little attention has been directed toward the health of adolescents, particularly in the area of sexual and reproductive health (SRH). Although a considerable amount of work has been initiated, there is still no organized program to provide reproductive health information and services to this group; this should be a concern because their age at marriage and premarital sexual activities are on the rise.

Information on reproductive health services is still not widely available to the entire population. Today, there are nearly four million adolescents ages 15–24, who are vulnerable to a great many health risks, including those related to SRH. Moreover, emotional and behavioral problems associated with alcohol and substance abuse, teenage pregnancies, illegal abortions, and reproductive tract infections such as sexually transmitted infections (STIs) are also present among adolescents.[6] Although abortion is illegal in Sri Lanka and may only be performed if the mother's life is at risk, a significant number of abortions are performed annually (150,000–175,000). It is also worth noting that adolescent girls' position within families and communities, their reproductive health, and their participation in public life are increasingly threatened by an alarming increase in gender-based violence, intimidation, and harassment of women.

Although the present state of ARH is as stated above, several promising strategies have been undertaken to inform adolescents about the reproductive health services that are available to them. Governments and nongovernmental organizations (NGOs) are involved in providing information and services, in particular health education and counseling services to adolescents. With a large percentage of both male and female adolescents in school, the provision of information within the formal school system needs to be strengthened to address concerns in this regard.

[6] De Silva, 1998a.

Figure 1: Total adolescent population ('000) (Ages 15-24)

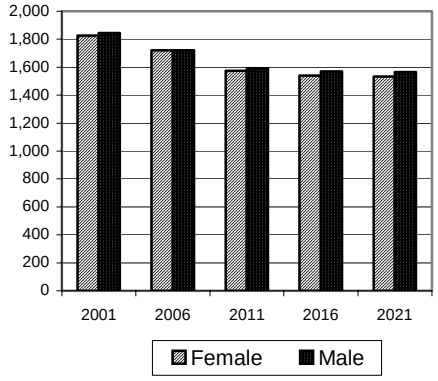


Figure 2: Years of education completed, 1994 (percent) (Ages 15-24)

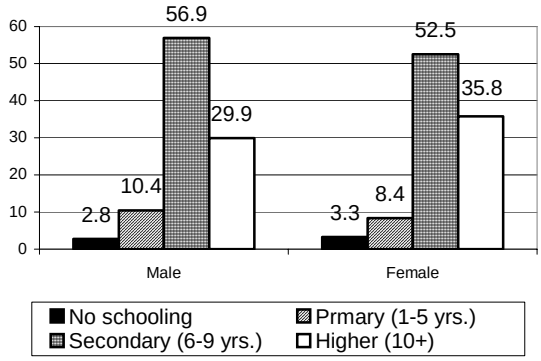
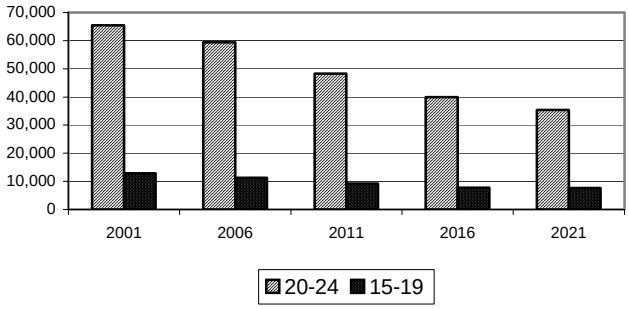


Figure 3: Employment by sex, 2000 ('000) (Ages 15-24)

Figure 4: Annual pregnancies (Ages 15-24)



2 SOCIAL CONTEXT OF ARH

Gender socialization

Adolescents in Sri Lanka face lower levels of gender discrimination at home and at school relative to adolescents in the rest of South Asia. However, despite performing as well as, if not better than, their male counterparts at school and university (see below), Sri Lankan women continue to be burdened with productive, reproductive, and societal expectations. A 1994 survey of women showed that although women were entering the labor force at faster rates than men, the rate of increase in the proportion of women holding senior administrative, planning, and scientific research jobs remained sluggish. Female representation at higher levels of government was also found to be minimal.[7] Moreover, anecdotal evidence and media reports suggest that female adolescents are subjected to gender-based violence in their own homes and homes in which they are employed as domestic servants.[8]

Education

In 1998, education was made compulsory for the 5–14 year-old age group. While the primary motivation for this reform was the protection of a large number of children who were not attending school and who were subject to various forms of abuse such as child labor, it has also been conducive to increasing girls' enrollment in schools.

Enrollment figures for school students show very few disparities between girls and boys. Girls appear to fare better than boys in public examinations and are more likely to enroll for higher education. School participation rates for the 15–19 year-old age group were 55.3 percent for girls and 55.4 for boys in 2000.[9]

Curtailed education

Dropping out mostly occurs in secondary school. Poverty is the main reason cited by adolescents for dropping out of school.[10] Educational attainment is also strongly associated with family socioeconomic background. Having a single parent, the school environment, and teachers' behavior are some of the indirect reasons cited for dropping out of school.

Employment

The legal age for employment is 18 years. Estimates of girls employed in domestic labor are generally unreliable because there is significant under-reporting of employed children younger than the statutory age of 18. The highest participation rate for females in the labor force is reported to be in the 20–24 year-old age group, with 51 percent of all females in that group employed.[11] It is estimated that at any one time, approximately 400,000 young Sri Lankan men and women are employed in the Middle East and other Asian countries. Young men make up most of the adolescent labor force and young women face higher rates of unemployment (Figure 3).

[7] Department of Census and Statistics, 1997a.
[8] Women and Media Collective, 2002.
[9] UNFPA, 2001.
[10] De Silva, 1994; Rupasinghe, 1984.
[11] Department of Census and Statistics, 2001a.

Marriage

During the past century, females' average age at marriage in Sri Lanka has increased by almost seven years. Delays in marriage and their impact on the birth rate led Kirk to refer to Sri Lanka as "the Ireland of Asia."[12] Caldwell and others identified Sri Lanka as a leader in third world Asia's change in marriage patterns; by the mid-1970s Sri Lankan women were marrying not at puberty, but a decade after that.[13] The age at marriage for women increased from 18.1 years in 1901 to 24.6 in 2000.[14]

The legal age of marriage for both men and women is 18 years. Although the mean age at marriage is older and child marriage practices do not exist, about one-quarter of women ages 20–24 married before reaching the age of 20. The older age at marriage poses a new challenge, particularly among young men, who tend to marry later and be more sexually active before marriage compared with adolescent girls.

On the other hand, postponement of marriage for both males and females is attributed to increases in education and work opportunities for females. Studies have established that, relative to other variables, education has been more effective in delaying marriage.[15] As a result, the proportion of unmarried adolescents (ages 15–24) is on the rise and with it, the duration of premarital sex.[16] A survey conducted among unmarried youth in the 17–28 year-old age group in Kandy showed that a significantly large proportion of men and women had engaged in some form of sexual relations that could have exposed them to the risk of pregnancy.[17]

[12] De Silva, 1997b. Also see Kirk, 1969.
[13] Caldwell et al., 1989.
[14] Department of Census and Statistics, 2001b.
[15] Puvanarajan, 1994.
[16] De Silva, 2000.
[17] Silva et al., 1997.

3 ARH ISSUES

Early, high-risk pregnancy

Teenage pregnancy is a major concern because of its impact on the overall health and well-being of both mother and child. In particular, women younger than 18 years of age are at high risk for pregnancy-related illnesses and death.

Adolescents often report their pregnancies later than adult women. This behavior is associated with a lower level of psychological maturity and possession of fewer coping mechanisms. Maternal morbidity rates also tend to be high for adolescents.[18] Pregnant adolescents are more likely to suffer eclampsia and obstructed labor compared with women who are pregnant in their early twenties.[19]

Age-specific fertility rates (ASFRs) for females ages 15–19 years have declined from 35 per 1,000 in 1993 to 14 per 1,000 in 2000. The ASFR for the 20–24 year-old age group declined from 110 to 72 per 1,000 during the same period. Females ages 15–24 have contributed to about 25 percent of the total fertility in 2000 and according to projections, their future contributions will also decline. [20,21]

According to the most recent DHS, over 95 percent of adolescent women who gave birth received prenatal care at a clinic or from a family health worker who visited their homes. It also found that 96 percent of adolescent mothers gave birth at a government hospital, maternity home, or private nursing home and were assisted at birth by a doctor, nurse, or health worker.[22]

Unwanted pregnancy, abortion

The incidence of unwanted pregnancies among adolescents in Sri Lanka is exceptionally low by international standards, primarily due to socio-cultural reasons. The unwanted pregnancies that do occur among unmarried adolescents are thought to end in abortions. Approximately 19 percent of abortion seekers interviewed in two separate studies were identified as adolescents ages 15–24, the majority of whom were married.[23] Although abortion is illegal in Sri Lanka for the political reasons described below, abortion services have always been provided at private hospitals and clinics, and occasionally at government hospitals. A 1993 study of 322 women who had experienced one or more induced abortions found that just over 80 percent of those abortions had taken place at a private clinic, hospital, or government hospital.[24]

Most adolescents, both married and unmarried are aware of the different methods of contraception and their advantages. Contraceptive use is relatively high among married adolescents. In 2000, 65 percent and 79 percent of ever-married adolescent women ages 15–19 and 20–24, respectively, reported using a method of contraception; 55 percent and 66 percent of the same groups used modern methods. However, contraceptive use among unmarried adolescents is far less widespread because of difficulties in obtaining contraception and cultural taboos. There is a great paucity of data on these issues and any observations are

[18] De Silva, 1998b.
[19] Senanayake, 1990.
[20] Department of Census and Statistics, 2001b.
[21] De Silva, 1997a.
[22] Department of Census and Statistics, 2002.
[23] De Silva et al.2000; Rajapaksa and De Silva, 2000.
[24] FPASL, 1993.

based on anecdotal evidence and small-scale studies. For instance, a small sample study done in Kandy of unmarried youth ages 17–26 found that only 12 percent of young men and 6 percent of young women had ever used contraceptives. Several of the young women had experienced abortions.[25] The use of condoms is relatively low among adolescents.[26] However, this is no different than the rest of the population, in which condom use is not widespread. The 2000 DHS found that although 85 percent of all married women reported having used a form of contraception, only 14 percent used condoms.[27] Thus, although unmarried adolescents are aware of contraception, usage is quite low. This poor association between knowledge and use of contraception has drawn the attention of health planners in recent years.

HIV/AIDS and STIs

The 2000 DHS found that 70 percent and 80 percent of ever-married women ages 15–19 and 20–24, respectively, were aware of HIV/AIDS and other STIs and knew of at least one method of prevention. The same survey found that only 20 percent of ever-married male and female adolescents were aware of the symptoms of STIs. In the absence of good data on STI awareness among unmarried adolescents, DHS data on married adolescents may be used as an upper bound because married couples are likely to have greater access to information about reproductive health information. With relatively low prevalence of premarital sex among adolescents because of socio-cultural reasons, poor awareness of HIV/AIDS and STIs is primarily a concern for specific high-risk groups. These groups include adolescent workers in the free trade zones, beach boys and girls involved in commercial sex and sex-tourism, and displaced persons, all of whom have been identified by policymakers as groups who are at a high risk of being infected with HIV/AIDS and STIs.

Recent statistics on adolescents attending STI clinics show that more girls than boys access STI services. The majority of such users are uneducated, are likely to have more than one sexual partner, and have practiced unprotected sex.[28] This reflects the highly medicalized nature of Sri Lankan society; the universality and ease of access to modern medical services has allowed Sri Lankans to seek care rapidly, even for minor illnesses. Adolescent sex workers are no exception to this trend.

There is a specialized unit within the health system infrastructure that deals with HIV/AIDS and STIs. This unit, in conjunction with the Health Education Bureau of the Ministry of Health, is actively involved in the prevention and control of HIV/AIDS and STIs through health education programs. Though the prevalence of AIDS is low in Sri Lanka, STI prevalence is on the rise among adolescents. Thus, it is important to inform adolescents about the causes and risks of STIs and the link between HIV/AIDS and STIs to prevent their spread.[29]

[25] Silva et al., 1997.
[26] Department of Census and Statistics, 2002.
[27] Department of Census and Statistics, 2001b.
[28] Department of Health Services, 2000.
[29] Department of Health Services, 2000.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

Legal barriers

Working mothers in the public sector are entitled to three months of maternity leave and breaks for breastfeeding for up to six months. These amount to fairly generous benefits for mothers. Similar benefits are offered to women employed in the private sector for their first and second births. It is worth noting, however, that maternity benefits in the private sector may be offered at the discretion of the employer.

With the exception of a few countries, the worldwide trend toward the liberalization of abortion laws has continued throughout the 20th century.[30] In Sri Lanka, the present Penal Code, which is over 100 years old, does not allow pregnant women to undergo induced abortion. It may only be performed if the mother's life is in danger. In 1995, amendments to the Penal Code were proposed to allow for abortion in instances of conception taking place as a result of an act of rape or incest, or in which fetal abnormalities were found. The amendments were not realized due to opposition mainly from the Catholic members of the legislature.[31] At present, there is an ongoing debate on the issue of abortion in Sri Lanka, and there is also wide disagreement as to the extent of legalization or non-legalization of abortion.

Existing ARH policies

In pursuance to the broadly defined concept of reproductive health adopted at the International Conference on Population and Development held in Cairo in 1994, the government appointed an inter-sectoral task force to formulate a national population and reproductive health policy and an action plan. The immediate mandate of the task force was the articulation of a policy and an action plan that indicates the precise mechanisms and processes for policy implementation. The task force attempted to capture the reality of emerging trends in the health population of the country.[32]

Population and Reproductive Health Policy

The Population and Reproductive Health Policy was approved on December 23, 1997 by the national health council, chaired by the Prime Minister. The cabinet ministers approved the policy on August 27, 1998. The policy consisted of eight goals to be achieved within the next 10 years.[33] They are as follows:

1. Maintain current declining trends in fertility so as to achieve a stable population size by the middle of the 21st century, at least.
2. Ensure safe motherhood and reduce reproductive health system-related morbidity and mortality.
3. Achieve gender equality.
4. Promote responsible adolescent behavior.
5. Provide adequate health care and welfare services for the elderly.
6. Promote the economic benefits of migration and urbanization while controlling their adverse social and health effects.
7. Increase public awareness of population and reproductive health issues.

[30] Paxman et al., 1993.
[31] De Silva et al., 2000.
[32] UNFPA, 2001.
[33] Ukwatta and De Silva, 2000.

8. Improve population planning and the collection of quality population and reproductive health statistics at the national and subnational levels.[34]

The fourth goal in the population and reproductive health policy put special emphasis on the health and well-being of adolescents. In doing so, it recognized the need to promote responsible, caring attitudes and sexual behavior among adolescents in order to mitigate the effects of social problems, such as HIV/AIDS and STIs and teen pregnancy.[35]

School health

The main objective of the school health program, implemented by the Department of Education, is to empower school children to act as changing agents to improve the health of their families and communities. The program is expected to strengthen the partnership between the health and education sectors while promoting the health of school children. The school health program has been implemented with the help of health and education officials, teachers, teacher's unions, students, parents, health providers, and community leaders in an effort to make the school a healthy place.[36]

One of the early attempts to provide reproductive health education in schools dates back to 1973, when the Department of Education embarked on a population education program funded by the UNFPA. The introduction of population education in schools was considered a bold and innovative step at the time. A population and family life education project funded by the UNFPA was undertaken by the National Institute of Education (NIE) in 1993 to promote reproductive health education in schools and to include selected reproductive health components into the school curriculum at different grades.[37]

Marriage

The minimum legal age at marriage is currently 18 years for both males and females in Sri Lanka. In 1998, the government amended and added to the legislation, thus materially improving the position of women in society. One of the more significant legal reforms for women's health and reproductive health rights was the increase in the legal age at marriage for women from 14 years to 18 years. This has a dampening effect on the incidence of teenage pregnancies and makes the offense of statutory rape effective for sexual intercourse with a female younger than 18, even with consent. This provision is not available to women of the Muslim faith who continue to be governed by Muslim law, which permits females to marry at 12 years of age.[38] DHS data have shown, however, that no more than 9 percent of women, including Muslims, marry at an age younger than 20.[39]

Motherhood and childhood

The Constitution of Sri Lanka provides for the protection of mothers, children, and adolescents and guarantees women's right to medical, physical, psychological, and social health care. In 1998, the government amended the legislation, again significantly improving the position of women in society. It entitled working women to maternity leave and breastfeeding breaks during work.

[34] Ministry of Health and Indigenous Medicine, 1998.
[35] De Silva, 1998a.
[36] Ministry of Health, 2001.
[37] Ministry of Health, 2001.
[38] UNFPA, 2001.
[39] Department of Census and Statistics, 2001b.

The rights of children, including female children, are enshrined in the Constitution and in the Children's Charter of 1992. Public interest in the protection of girl children has grown in recent times because of the publicity surrounding child prostitution and gross acts of abuse committed against girl children. The 1995 amendment to the penal code enhanced the protection of children and strengthened the punishment for offenses committed against children. Such offenses include cruelty to children, sexual exploitation of children, child pornography, and incest. The National Child Protection Authority has been empowered to act expeditiously to protect and prevent child abuse.[40]

[40] UNFPA, 2001.

5 ARH POLICY INITIATIVES

ARH strategy

There are various strategies for promoting ARH in Sri Lanka. In 1993, the Family Health Bureau (FHB) of the Ministry of Health established a national steering committee, with representation from the Faculty of Medicine (Colombo), Ministry of Education, Department of Education, and NGOs involved in adolescent health programs, to address issues related to adolescent health. The FHB functioned as the secretariat to this committee. This committee has had a series of consultations, in which a set of recommendations regarding the promotion of adolescent health was developed. Also, with necessary guidance from the committee, a book on common adolescent health issues was developed for higher grade school children titled *Dawn of Adolescence* (*Udawu Yauvanaya*). The FHB has incorporated adolescent health into their training programs so that the public health sector staff would be able to provide necessary advice and counseling during their routine work.[41]

Sri Lanka's primary needs and priority strategic actions addressing the reproductive health needs of adolescents and young people will be of utmost importance in the medium term. Therefore, it is recommended that family life education and sex education be strengthened and extended throughout the education system. This would, as a corollary, need the recruitment and training of appropriate teachers and the preparation of training modules.[42]

The ARH strategy also seeks to promote counseling for out-of-school youth. A project initiated by the Family Planning Association of Sri Lanka (FPASL) and funded by the European Commission/United Nations Population Fund (EC/UNFPA) was launched in 1998 to provide reproductive health information, counseling, and health care services to adolescents.

New political support to focus on adolescents

Recent heads of state have given priority to the living conditions and needs of adolescents. The Parliament frequently discusses problems pertaining to population and reproductive health, especially the need for reproductive health information, counseling, and health care services for adolescents. Greater awareness of population issues and reproductive health is also evident among elected officials at subnational levels.[43]

[41] UNFPA, 2001.
[42] UNFPA, 2001.
[43] UNFPA, 2000.

6 ARH PROGRAMS

Public sector

ARH programs are implemented through the Department of Education, the National Youth Service Council (NYSC), and NGOs working in this field. Sri Lanka also took part in the Reproductive Health Initiative (RHI) in Asia—an EC/UNFPA exercise that addressed adolescents and their reproductive needs. The project commenced in 1999, covered 13 districts and focused on counseling and provision of services for adolescents.[44] As part of the project, 12 public health midwife (PHM) areas were established in each of the 13 districts to provide services to a total of 150,000 adolescents. A consortium of seven NGOs implemented the project and FPASL coordinated the activities. The project envisaged the establishment of counseling and service delivery points (SDPs), the majority of which were located in schools. Over 575,000 adolescent have used the counseling services and SDPs. An advisory committee for the project consisting of representatives from the government, the EC, FPASL, and UNFPA, along with several persons with relevant expertise in Sri Lanka, provided advice and guidance to ensure satisfactory implementation of the project regarding reproductive health information, counseling, and services to adolescents.[45]

Both general reproductive health education and counseling have proved to be important in the Sri Lankan context. Reproductive health information and education enable adolescents to make informed choices and decision in matters of reproductive health. However, counseling is needed only by adolescents with reproductive health problems for which counseling can help.

The Ministry of Health established Well Women Clinics in 1996. There are 262 Well Women Clinics operating at present. They represent a more holistic approach taken by the government to women's reproductive health care in Sri Lanka. Adolescents, unmarried women and others who do not have direct access to government health services are encouraged to attend these clinics.

National Youth Campaign

In Sri Lanka, the National Youth Campaign has been implemented through the NYSC. It was established in 1970 with the express purpose of helping out-of-school youth in the 15–29 year-old age group. It is responsible for policymaking, planning, and coordinating activities at the national level.[46]

The NYSC, with support from UNFPA, undertook the Reproductive Health Information Project in 1997 with the objective of providing leadership training for youth and peer groups. The training covered issues such as HIV/AIDS and STIs, drugs, family planning, and empowerment of women.[47] In 2000, the youth leaders managed to conduct a total of 51 peer group training sessions at the youth club level. The trained youth leaders, with the help of health officials, provided messages on reproductive health to their peers in the youth clubs. The seminars raised awareness on reproductive health issues among a total of 2,800 out-of-school youth. Some youth leaders even went outside their respective youth clubs to educate and inform different vulnerable groups on reproductive health problems. NYSC also organized a street drama group to increase awareness about HIV/AIDS, STIs, and family planning. It was conducted as a series of seven performances in two districts. NYSC has also held two-day workshops attended by the 120 NYSC

[44] Gnanissara, 2002.
[45] Gnanissara, 2002.
[46] UNFPA, 2001.
[47] UNFPA, 2000.

project staff from the districts as well as from the headquarters. The purpose of these workshops is, again, to educate youth about reproductive health issues.[48]

Telephone hotlines

The FPASL has launched a hotline service to provide medical information on reproductive health issues. The hotline was specifically launched to introduce emergency contraception to the at-risk population. Although it does not specifically target youth or adolescents, there are young callers among the 80–90 calls that are received per day.[49]

NGOs such as *Sumithrayo* have also launched a hotline service to target youth. They are concerned primarily with the emotional problems of youth, not reproductive health issues per se. However, there are adolescents who use this hotline service to obtain advice on reproductive health issues.

Peer education

The aim of the peer education program, which has been implemented in universities, is to raise awareness among the peer groups. The main objective of the peer education program is to improve the awareness of first-year university students on issues related to reproductive health, as well as making reproductive health counseling available to them when needed. The program was implemented through a series of lectures to first-year students. The peer group counseling initiative, in which senior students are trained to counsel and give reproductive health information to first-year students, was not very successful because it was not implemented properly.[50] For instance, a booklet containing reproductive health information that was published as part of the initiative was never distributed to the students because of controversy regarding its contents.

School-based health education

School-based health education is a valuable approach to increasing awareness of reproductive health issues. A population and family life education project was undertaken by the NIE in 1993 with UNFPA funding to promote reproductive health education in schools and to include selected reproductive health components into the school curricula in different grades.[51] In general, the Health Education Bureau (HEB) of the Ministry of Health is responsible for providing necessary information, education, and communication (IEC) support for the school-based health education.

As part of the school health program, 1,074 school health clubs were established in 10 high-risk districts by HEB, in close collaboration with the regional health authorities and UNICEF. These clubs provide an opportunity for young adults (senior students) to discuss issues related to sexual behavior and responsible living and to enhance their knowledge of reproductive health issues, including HIV/AIDS and STI prevention, through lectures and seminars.[52] A training program for teachers of social studies, science, health, and physical education was also set up under this project. They were trained on how to address the newly emerging issues of population and reproductive health in their classes. Teacher counseling sessions were conducted. The teachers then received practical and specialized training on how to counsel adolescents on issues related to reproductive health.[53] In addition, the project distributed a booklet titled

[48] UNFPA, 2000.
[49] Personal interview with FPASL.
[50] Personal interview with University Grants Commission, 2002.
[51] Ministry of Health, 2001.
[52] UNFPA 2001.
[53] UNFPA, 2000.

Most Asked Questions and Answers on Reproductive Health, containing the 75 reproductive health-related questions that are most frequently asked by students.[54]

Community-based interventions

In 1998, FPASL launched a series of projects to provide reproductive health information, counseling, and services to adolescents. They were funded by EC/UNFPA under an initiative to enhance reproductive health in Asia. FPASL selected 156 midwife areas in 13 districts (with a total population of around 500,000) to implement the project. One objective of the project was to provide community-based sexual and reproductive health information and services to adolescents, with a special focus on those living in vulnerable or under-serviced areas. This was achieved through the establishment of community Counseling Service Points (CSPs) that were staffed by trained counselors and volunteer workers. Their task was to encourage adolescents with problems to seek counseling at the CSPs.[55] The project started off by providing SRH counseling through part-time, community-level counselors to adolescents who had been identified as being in need of information and services. Another objective was to improve the community's awareness and involvement in providing SRH information and services to adolescents. The project mobilized the support of parents, teachers, communities, and administrative and political leaders. A high level of community support was achieved through a series of advocacy seminars conducted to sensitize the community on the importance of addressing any unmet need for SRH services among adolescents on a timely basis.[56]

The nongovernmental sector

NGOs are important stakeholders in the national reproductive health and gender programs and are recognized by the government. The NGO sector provides an important supportive function to government programs, especially in the areas of family planning, adolescent health, and STI/HIV prevention. Four NGOs complement government family planning programs at present. Many other NGOs have been involved in programs related to the education, training, and counseling of adolescents. The Reproductive Health Information, Counseling, and Services to Adolescents and Youth Project was implemented by seven NGOs, namely, FPASL, Sarvodaya, Worldview Sri Lanka, SLAVSC, CDS, Vinivida Federation of Community Based Organization, and Prevention of Cancer and AIDS.[57] These NGOs have been conducting effective programs to train peer counselors on reproductive health issues, with the objective of improving knowledge on reproductive health and sexuality, providing skills in sexual health-related communication, and fostering attitudes that support low-risk behaviors. Another NGO, Sumithrayo, is an NGO that deals with adolescent health and sexual and emotional problems.

Several NGOs, in collaboration with UNFPA, have implemented a project to distribute condom vending machines island-wide. The project targets vulnerable groups such as the Free Trade Zone workers, the plantation and rural community, youth, adolescents, and army personnel. Its objective is to encourage the use of condoms as a temporary method that will not only prevent the spread of STIs but also reduce the incidence of unwanted pregnancies and improve the reproductive health status of the population.

The International Rotary Society, in collaboration with the UNFPA, is involved in important advocacy work on reproductive health issues among adolescents at school. This project focuses on raising awareness on HIV/AIDS and STI issues and providing information on the importance of sound

[54] UNFPA, 2000.
[55] UNFPA, 2001.
[56] Gnanissara, 2002.
[57] Gnanissara, 2002.

reproductive health and responsible sexual behavior, especially responsible male behavior and the prevention of HIV/AIDS and unwanted pregnancies.[58]

Operations research

UNFPA supports a few crucial research studies that have a bearing on policy and are of relevance to the operational programs. The Population Division of the Ministry of Health, under the UNFPA-funded project, has subcontracted 19 research studies on reproductive health to relevant individuals and organizations. Fourteen studies have been submitted. A summary of the 14 studies was presented at a workshop held in December 2000. In addition, the University Grants Commission has provided grants for students and staff to conduct research on reproductive health.[59]

Programs beyond health

Services to youth and adolescents are a crucial areas warranting UNFPA support. UNFPA has supported a multipronged approach to provide information and services that include counseling service for young men and women in their late adolescent years.

Several organizations and institutions outside of the health sector have implemented programs concerned with the reproductive health of adolescents. They include the HEB, the Workers Education Division of the Labor Department, NYSC, the Vocational Training Authority, and the University Grants Commission. These programs have emphasized the importance of responsible sexual practices and strived to improve awareness of issues related to sexuality. The Women's Bureau is also involved in a reproductive health project that advocates for a broader approach to reproductive health issues, including the reproductive health rights of women, gender equality, and women's empowerment.[60]

[58] UNFPA, 2000.
[59] UNFPA, 2000.
[60] UNFPA, 2000.

7 OPERATIONAL BARRIERS TO ARH

Lack of knowledge and public awareness about ARH issues

Though a considerable amount of work has been initiated, there is not yet an organized program to provide ARH counseling and information services to vulnerable groups. This is of concern given the rising age at marriage, which in turn has led to a rise in premarital sexual activities.[61] As discussed earlier, knowledge about the different methods of contraception is fairly widespread among adolescents, especially married ones. However, there is a need for greater dissemination of information about sexual and reproductive health issues. Focus group discussions conducted in several schools as well as among school dropouts show that adolescents would like to increase their knowledge about sexuality.[62] The lack of counseling and information services is associated with the fact that there is a dearth of health workers and professionals who have the necessary skills and experience to counsel on ARH issues and provide advice on HIV/AIDS and STIs.

There is also little public awareness about ARH in Sri Lanka, primarily due to cultural taboos that have made it difficult for parents, teachers, and community leaders to openly discuss key issues among themselves or with adolescents. As a result, the usual channels of information on safe sex, reproductive health, and countering peer pressure are not available to adolescents. The same cultural taboos that have inhibited open discussion on ARH issues have also hampered marketing campaigns to promote greater use of contraceptives. Promotional campaigns have had to be sensitive to local cultural and religious beliefs.[63]

Inability to obtain services

Reproductive health clinics or centers at which adolescents are willing and able to seek services are virtually non-existent in Sri Lanka, thus posing a serious threat to good ARH in the country. Unmarried adolescents are not directly targeted for contraceptive services at present. Until recently, PHMs provided contraceptives at a highly subsidized price to married couples only. These services have now been extended to unmarried adolescents as well. However, the Ministry of Health is aware that the proportion of unmarried couples who obtain such services from PHMs is actually quite low and that they are more likely to buy contraceptives at private pharmacies, albeit at a higher price.[64] Collecting information about a spouse at the point of service is another factor that may deter adolescents from obtaining contraceptives from government-sponsored family planning programs, although this practice no longer exists.[65] The Ministry of Health recently set up an adolescent clinic at one of the large tertiary hospitals in the capital city, Colombo. This clinic is the first of its kind.

Lack of community awareness about the reproductive health needs of adolescents, limited availability of reproductive health services to adolescents, and inadequate opportunities for adolescents to learn about reproductive health issues thus represent significant operational barriers to ARH services.

[61] De Silva, 2000.
[62] Personal communication with FPASL, 2002.
[63] Interview with Deepthi Perera, MOH Director responsible for Adolescent Health.
[64] Interview with Deepthi Perera.
[65] UNFPA, 2001.

Lack of data on ARH issues

There is an obvious lack of reliable data on ARH issues, such as teenage pregnancies, abortions, contraceptive use, child abuse, and gender-based violence. These issues are no doubt sensitive to discuss and difficult subjects for data collection. However, as long as data are scarce and the severity of ARH issues is not made known to the public, political commitment for a coherent ARH policy initiative will be difficult to achieve. In the long run, this could prove to be the greatest operational barrier to ARH in Sri Lanka.

8 RECOMMENDATIONS

Capitalize on the political support for reaching adolescents

Although political leaders often express strong interest in solving problems faced by youth, including articulating the post-Cairo policy that explicitly lists youth, it is not possible to expect their direct involvement in ARH. More involvement from organizations directly associated with ARH is therefore essential. The government could, however play a key role in encouraging NGOs to adopt needed policies and programs that support ARH services. Greater collaboration with politicians is desirable not only to strengthen the implementation of the projects but also to create a supportive environment in which the continuity of services is assured.

A holistic approach to adolescent health

Although there are numerous programs in place to enhance ARH, they do not necessarily constitute a successful solution to problems associated with ARH. The Well Women Clinics do, however, represent a shift to a more holistic approach to adolescent health programs. Reproductive health interventions, which involve different social sectors, including education and labor, also have strong potential in this regard. Meanwhile, legislative action has been effective in influencing risk-taking behavior among adolescents. Thus, a combination of public policy that is multisectoral in nature and legislation is needed to improve ARH in the long run.

Provide information to adolescents

School-based programs are unrivaled when it comes to providing information on SRH to adolescents. Other effective means of providing information include peer counseling and the mass media. The media must adopt new approaches to make the public more aware of reproductive health issues. All methods must pay special attention to those living in vulnerable and under-served areas.

The expansion of counseling services to adolescents relies heavily on the availability of trained counselors. Around 500 counselors have been trained so far, but this is far from sufficient. Increased training of teacher-counselors through the National Institute of Education is therefore desired.

Improve pre-marital counseling

Premarital counseling is an excellent opportunity to provide useful information and counseling to young couples and adolescents. Sexual and reproductive health counseling should also be strengthened through part-time counselors at the community level. Those adolescents or young couples who are about to get married should be provided with adequate counseling services that involve issues such as family planning and responsible sexual behavior.

Work through the pharmacy network

The network of pharmacies provides an alternative means to reach adolescents with appropriate information, methods of contraception, and disease prevention. If adolescents and unmarried couples are unable or unwilling to obtain public health services directly, pharmacies could provide reliable and confidential services. The pharmacist should be provided with the necessary training to deal with adolescents seeking SRH services.

Conduct research on sexual behavior and special population groups

It is important to investigate ARH problems through a variety of research programs on adolescents. Although some initial research projects created high levels of awareness about reproductive health and the reproductive health status of special population groups, such as prostitutes, beach boys, and university students, special programs implemented for these groups have not yet proved successful. For this reason, there is a need for further research in the country.[66]

Research must also cover special population groups and important subject areas such as abortion, gender-based violence, high-risk behaviors, and commercial sex, which are directly relevant to the reproductive health of adolescents. These research studies should use appropriate study designs to collect the necessary information.

[66] De Silva, 2000.

APPENDIX 1. Data for Figures 1 through 4

1. Total adolescent population (000's)	2001	2006	2011	2016	2021
Males	1,844.7	1,721.0	1,591.8	1,569.6	1,566.1
Females	1,825.2	1,719.9	1,575.4	1,539.4	1,533.6

2. Level of education in, 2000 (%)	No schooling	Primary (grades 1–5)	Secondary (grades 6–9)	Higher (grades 10+)
Males	2.8	10.4	56.9	29.9
Females	3.3	8.4	52.5	35.8

3. Adolescent labor force, 2000 (000's)	Employed	Unemployed
Males	701	179
Females	393	159

4. Percentage of adolescent births of total births, 2001–2021	2001	2006	2011	2016	2021
Ages 15–19	12,824	11,289	9,249	7,701	7,651
Ages 20–24	65,457	59,375	48,275	40,003	35,368
Total	*319,699*	*314,628*	*299,899*	*274,081*	*247,175*

Assumptions and sources:

Figure 1. Population data were taken from the population projections for Sri Lanka produced by Indralal De Silva and commissioned by the Institute of Policy Studies in 1997.

Figure 2. Data on years of education completed in 1994 were obtained from a survey of demographic and housing characteristics carried out by the Department of Census and Statistics in 1997. The data do not include the northern and eastern provinces, where survey work could not be carried out due to the civil war at the time. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Employment data were obtained from the Sri Lanka Labor Force Survey carried out by the Department of Census and Statistics in 2000. The data do not include the northern and eastern provinces for the same reasons cited above.

Figure 4. Data on current and projected births were obtained from the same set of population projections cited in Figure 1.

REFERENCES

Caldwell, J.C., I. Gajanayake, B. Caldwell, and P. Caldwell. 1989. "Is Marriage Delay a Multiphasic Response to Pressures for Fertility Decline? The Case of Sri Lanka." *Journal of Marriage and Family* 51:337–351.

Department of Health Services. 2000. *Annual Health Bulletin, 2000*, Colombo: Department of Health Services.

Department of Census and Statistics. 1997a. *Changing Role of Women in Sri Lanka.* Colombo: Department of Census and Statistics.

Department of Census and Statistics. 1997b. *Sri Lanka Demographic Survey 1994, Report on Demographic and Housing Characteristics.* Release No.4, Colombo: Department of Census and Statistics.

Department of Census and Statistics. 2001a. *Sri Lanka Labor Force Survey, Third Quarter 2000*, Colombo: Department of Census and Statistics.

Department of Census and Statistics. 2001b. *Sri Lanka Demographic and Health Survey 2000, Preliminary Report.* Colombo: Department of Census and Statistics.

Department of Census and Statistics. 2002. *Sri Lanka Demographic and Health Survey 2000 – Final Report.* Colombo: Department of Census and Statistics.

De Silva, W.I. 1994. "Factors Associated with Non Schooling and Dropouts in Sri Lanka." *Rohana* 5:9–22. Matara: University of Ruhuna.

De Silva, W.I. 1997a. *Population Projections for Sri Lanka: 1991–2041*. Human Resource Development Series 2. Colombo: Institute of Policy Studies.

De Silva, W.I. 1997b. "Ireland of Asia: Trends in Marriage Timing in Sri Lanka." *Asia-Pacific Population Journal* 12(2):3–24.

De Silva, W.I. 1998a. "Socio-economic Change and Adolescent Issues in the Asian and Pacific Region." In *Report and Recommendations of the Expert Group Meeting on Adolescents: Implications of Population Trends, Environment, and Development*, Asian Population Studies Series 149:46–81. Bangkok: ESCAP.

De Silva, W.I. 1998b. "Puerperal Morbidity: A Neglected Area of Maternal Health in Sri Lanka." *Social Biology* 45(3–4):223–245.

De Silva, W.I. 2000. "Transition from Childhood to Adulthood: Reproductive Health Issues Among Adolescents in Asia-Pacific Region." pp. 1–31 in *Demography of Sri Lanka: Issues and Challenges.* Colombo: Department of Demography, University of Colombo.

De Silva, W.I., L. Rankapuge, and R. Perera. 2000. "Induced Abortion in Sri Lanka: Who Goes to Providers for Pregnancy Termination." pp.182–196 in *Demography of Sri Lanka: Issues and Challenges*. Colombo: Department of Demography, University of Colombo.

Family Planning Association of Sri Lanka. 1993. *Abortion in Sri Lanka*. Colombo: Family Planning Association of Sri Lanka.

Gnanissara, S.A.P. 2002. *Final Evaluation Report: Reproductive Health Information, Counseling and Services to Adolescents and Youth Project (RAS/98/P17),* EC/UNFPA Initiative for Reproductive Health in Asia, Colombo.

Kirk, D. 1969. "Natality in Developing Countries: Recent Trends and Prospects." pp. 75–98. in *Fertility and Family Planning: A World View*, edited by S.J. Behrman, L. Corsa, and R. Freedman. Ann Arbor: University of Michigan Press.

Ministry of Health and Indigenous Medicine. 1998. *Population and Reproductive Health Policy (1998*). Colombo: Ministry of Health and Indigenous Medicine.

Ministry of Health. 2001. *School Health Quarterly Return* (3rd Quarter 2001). Colombo: Ministry of Health.

Paxman, J.M., A. Rizo., L. Brown, and J. Benson. 1993. "The Clandestine Epidemic: The Practice of Unsafe Abortion in Latin America." *Studies in Family Planning* 24(4):205–226.

Puvanarajan, P. 1994. *Social Change and Fertility Transition in Sri Lanka.* Unpublished Ph.D. Thesis. Durham, United Kingdom: University of Durham.

Rajapaksa, L. and W.I. De Silva. 2000. Profile of Women Seeking Abortion. Colombo: University of Colombo.

Rupasinghe, S. 1984. "Participation of Early School Dropouts in Economic Activities." *Sri Lanka Journal of Social Sciences* 7(1&2):1–22.

Senanayake, P. 1990. "Adolescent Fertility" In *Health Care of Women and Children in Developing Countries,* edited by H.M. Wallace and K. Giri. Oakland: Third Party Publishing.

Silva, K.T., S.L. Schensul., J.J. Schensul, B. Nastasi, M.W. De Silva, C. Sivayoganathan, P. Ratnayake, P. Wedsinghe, J. Lewis, M. Eisenberg, and H. Aponso. 1997. *Youth and Sexual Risk in Sri Lanka.* Washington: International Center for Research on Women.

Ukwatta, S. and W.I. De Silva. 2000. "Development of Population and Reproductive Health Policy in Sri Lanka." pp. 32–52 in *Demography of Sri Lanka: Issues and Challenges*. Colombo: Department of Demography, University of Colombo.

UNFPA. 2001. *Sri Lanka: Country Population Assessment Report – 2001*. Colombo: United Nations Population Fund.

UNFPA. 2000. *Sri Lanka – 2000.* Colombo: United Nations Population Fund.

WHO. 1975. *Pregnancies and Abortion in Adolescence: Report of a WHO Meeting.* Technical Report Series 583. Geneva: World Health Organization.

Women and Media Collective. 2002. *Study on the Outreach Capacity of Public Health Midwives in addressing the Issue of Domestic Violence at the Level of the Community.* Colombo: Women and Media Collective.

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